Delaware Medical Journal

Official Publication of the Medical Society of Delaware

ESTABLISHED 1776 — 1789 INCORPORATED

SEPTEMBER, 1960 ....

STATE BOARD OF HEALTH ISSUE

VIRTUALLY NO DECREASE IN STAPHYLOCOCCAL SENSITIVITY

OVER AN 8-YEAR SPAN . . . TO

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

An outstanding and frequently reported characteristic of CHLOROMYCETIN[1-8] "...is the fact that the very great majority of the so-called resistant staphylococci are susceptible to its action."[1] In describing their study, Rebhan and Edwards[2] state that "...only a small percentage of strains have shown resistance..." to CHLOROMYCETIN, despite steadily increasing use of the drug over the years.

Fisher[3] observes: "The over-all average incidence of resistance, for the 31,779 strains [of staphylococci] through nine years was about 9%." Finland[4] reports that, while the proportion of strains resistant to several newer antibiotics has risen to between 10 and 30 per cent, such resistance to CHLOROMYCETIN "...has been rare even where this agent has been used extensively." Numerous other investigators concur in these findings.[5-8]

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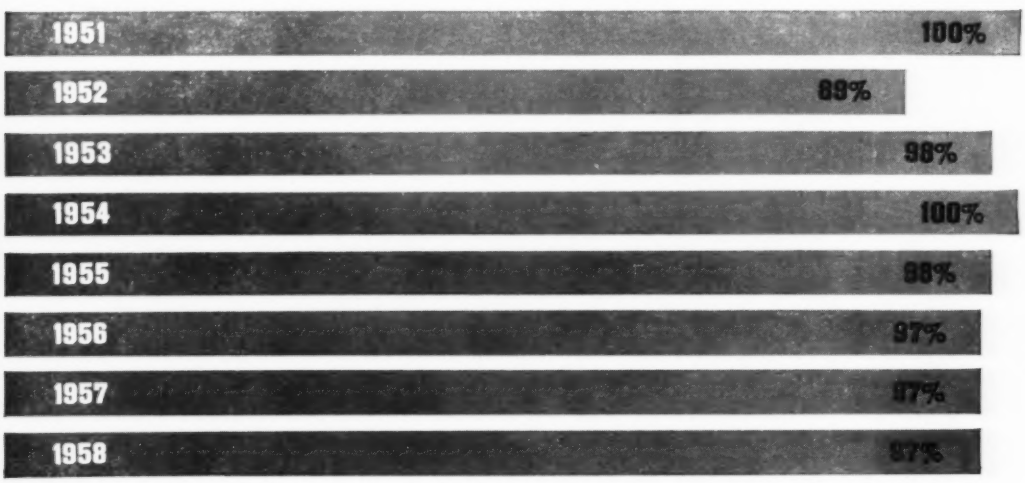
References: (1) Welch, H., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 1. (2) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* **82**:513, 1960. (3) Fisher, M. W.: *Arch. Int. Med.* **105**:413, 1960. (4) Finland, M., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 187. (5) Bercovitz, Z. T.: *Geriatrics* **15**:164, 1960. (6) Glas, W. W., & Britt, E. M.: Management of Hospital Injections, in Symposium on Antibacterial Therapy, Michigan & Wayne County Acad. Gen. Pract., Detroit, September 12, 1959, p. 7. (7) Staphylococcal Infections in Pediatrics, Scientific Exhibit, Commission on Professional and Hospital Activities, 108th Ann. Meet., A. M. A., Atlantic City, June 8-12, 1959. (8) Robinson, H. M., Jr.; Robinson, R. C. V., & Raskin, J.: *Postgrad. Med.* **27**:522, 1960.

IN VITRO SENSITIVITY OF PYOGENIC STRAINS OF STAPHYLOCOCCI TO CHLOROMYCETIN OVER A PERIOD OF EIGHT YEARS*



Statistics were gathered over almost a decade on 329 children with staphylococcal pneumonia; 1,663 sensitivity tests were performed.

*Adapted from Rebhan & Edwards.[3]

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MEDICAL SOCIETY OF DELAWARE

INCORPORATED 1789

Delaware Medical Journal

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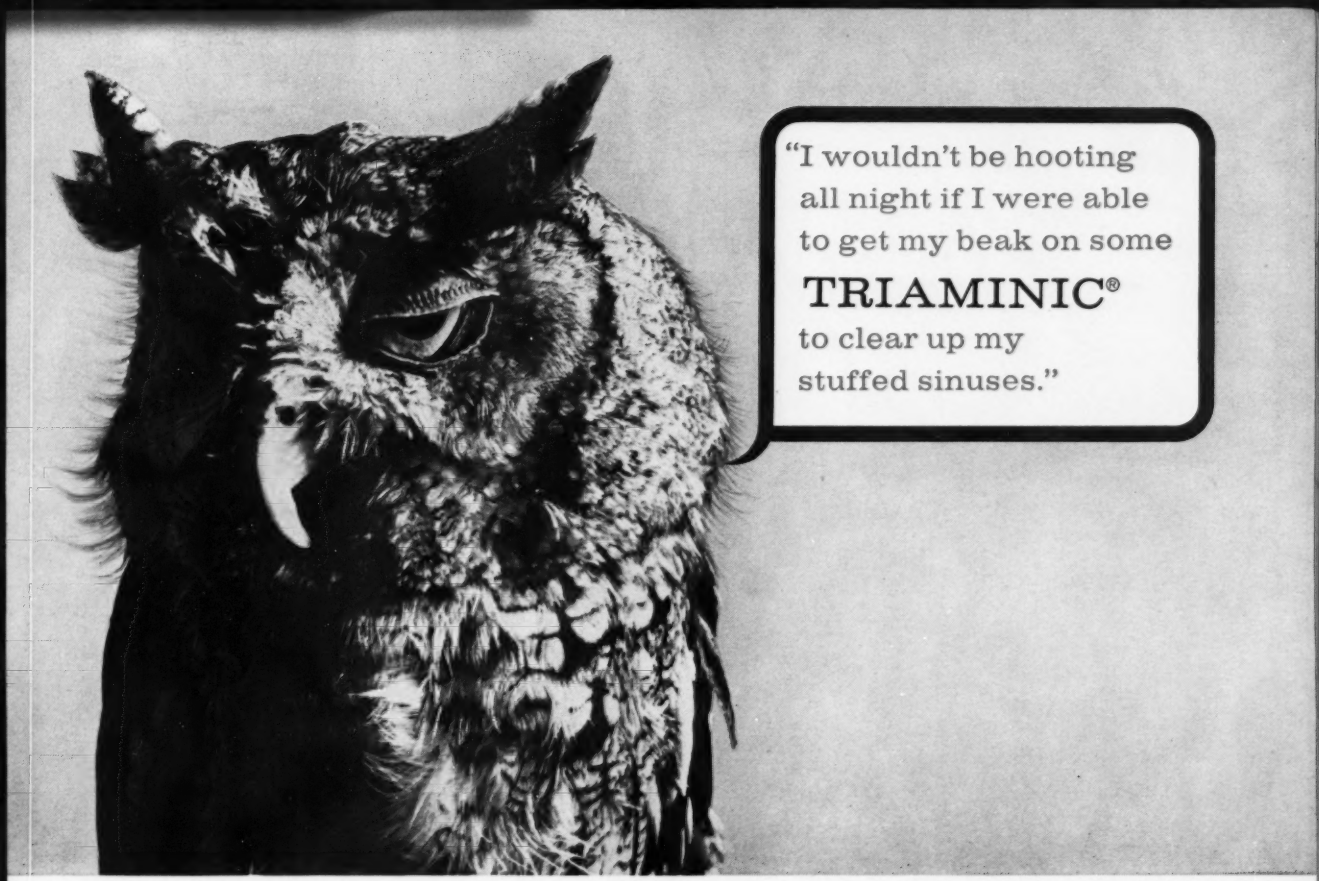

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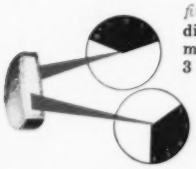

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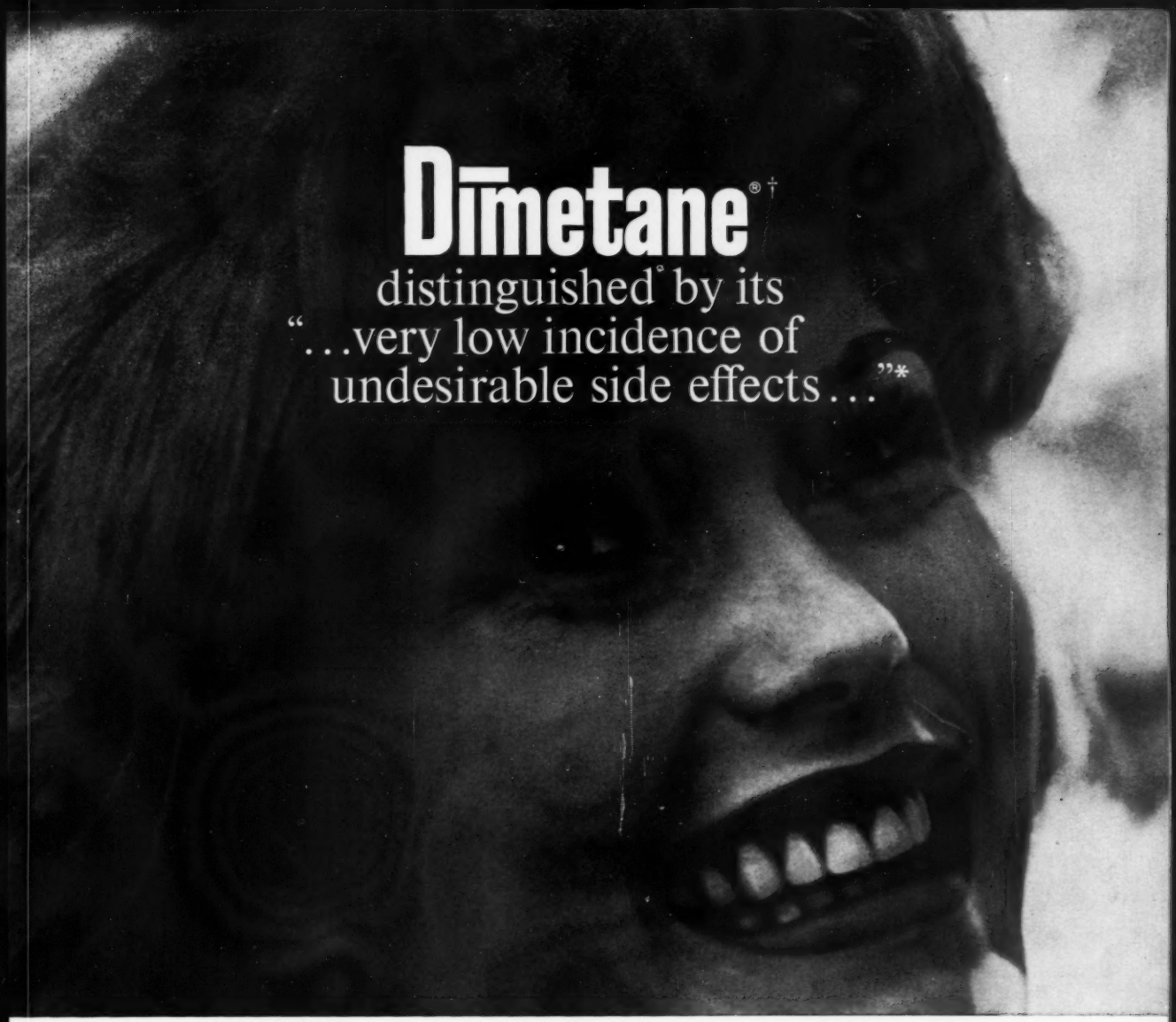

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*MC GOVERN, J. P., MC ELHENNEY, T. R., HALL, T. R., AND BURDON, K.D.: ANNALS OF ALLERGY 17:915, 1959.

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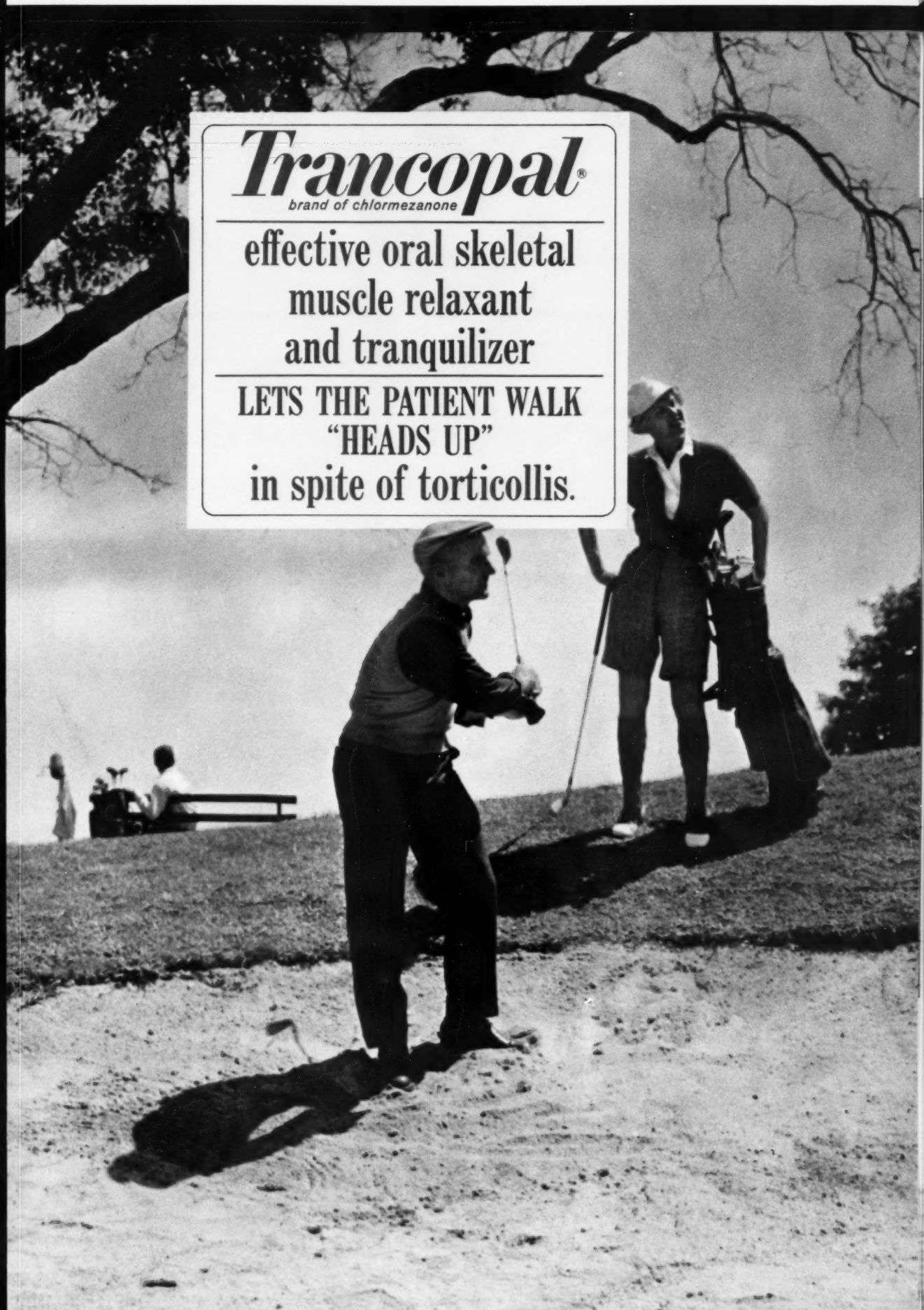
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1. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 2. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 3. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958.

Clinical results with *Trancopal*®[2]

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Chronic low back strain	11	5	1	1	18
"Porters' syndrome"*	21	5	1	1	28
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NECK SYNDROMES					
Whiplash injuries	12	6	2	1	21
Torticollis, chronic	6	2	3	2	13
OTHER MUSCLE SPASM					
Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
TENSION STATES	18	2	4	3	27
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*Over-reaching in lifting heavy bags resulting in sprain of upper, middle, and lower back muscles.

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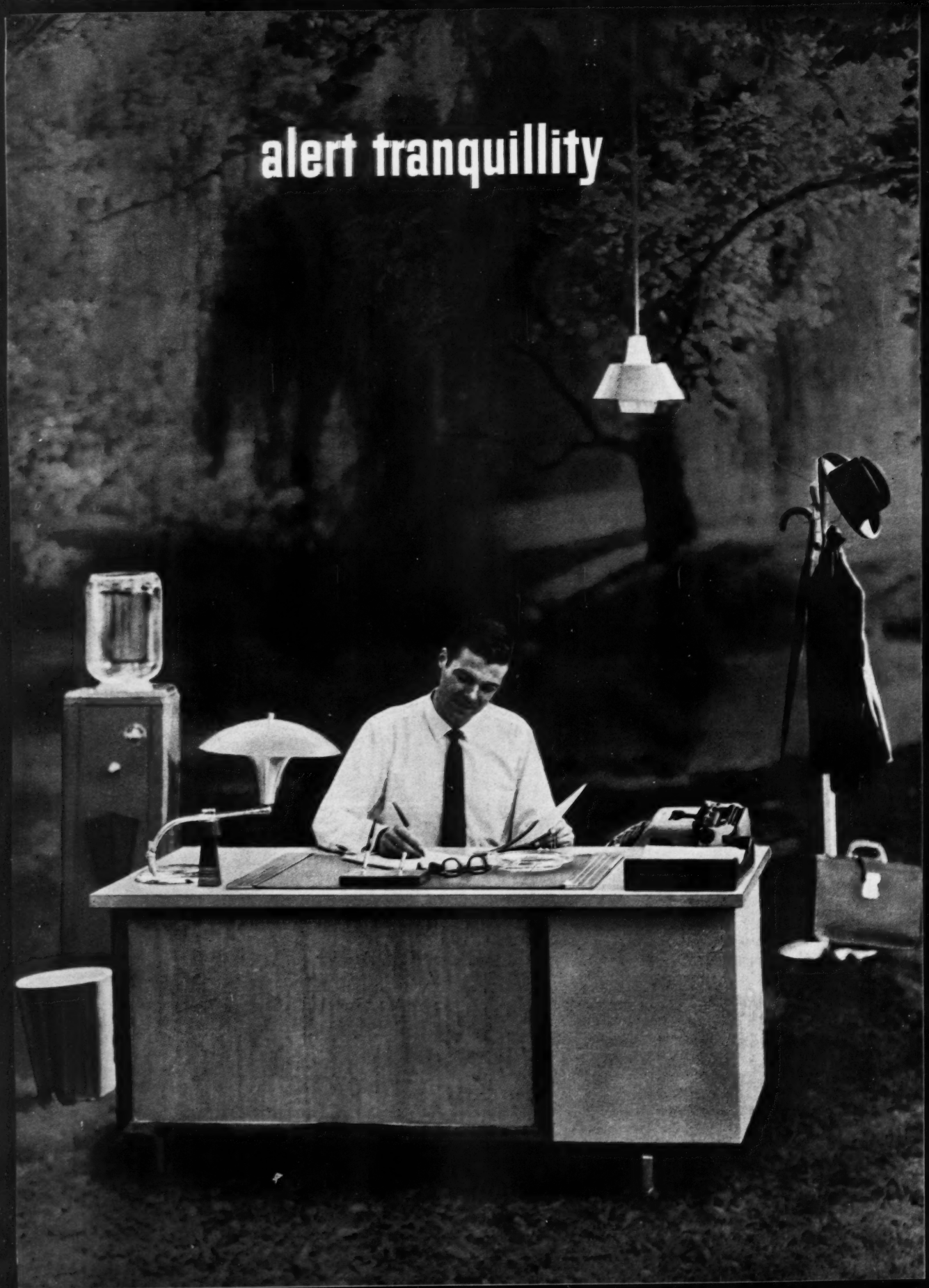
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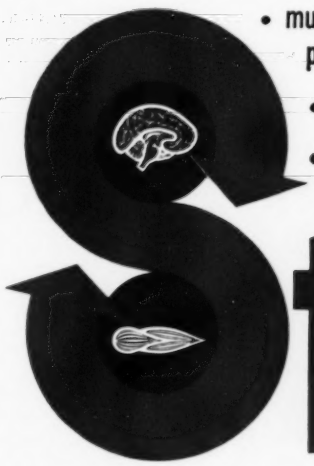

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- no new or unusual effects—such as ataxia or excessive weight gain
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Adult Dosage: One tablet three times daily, preferably just before meals. In insomnia due to emotional tension, an additional tablet at bedtime usually affords sufficient relaxation to permit natural sleep.

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Literature on request

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SEPTEMBER, 1960

NUMBER 9

VOLUME 32

Delaware Medical Journal

PREVENTION of MENTAL RETARDATION from PHENYLKETONURIA

FLOYD I. HUDSON, M.D.*

There is much in the literature of recent years pointing up the relationship between phenylketonuria and mental retardation. This easily recognized disease is one cause of mental retardation which is readily amenable to prevention by the physician and family. I shall not discuss the literature at length, but will give some information which will be helpful in the prophylaxis of this disease.

Phenylketonuria is an abnormality of metabolism which is transmitted through the genes. Infants born with this condition are normal in all respects but are unable to metabolize fully the essential amino acid phenylalanine. The result in unrecognized cases is an accumulation of phenylalanine in the blood and other tissues. This accumulation causes toxicity, primarily within the central nervous system. A mental retardation occurs which is permanent unless an early diagnosis is made and treatment promptly begun. It is highly important that the disease be discovered in the first few weeks of life if mental deterioration is to be prevented. Any physician can do a simple test to determine whether there is a possibility of the disease in any infant.

Phenylketonuria can best be detected during the second week of life. Simply place one drop of ten per cent (10%) aqueous solution of ferric chloride on the diaper which has been soiled with urine. Should a blue-green color appear in a matter of seconds, the test is positive. A yellow stain on the diaper signifies a negative test. Cases in which a positive reaction occurs should have a blood phenylalanine determination before treatment is started.

The treatment of the disease is dietary. It is necessary to prescribe a diet low in phenylalanine to maintain normal limits of this amino acid in the blood. (The Board of Health's nutrition consultant will be glad to assist any physician upon request.) Repeated blood tests should be made periodically to assure that treatment is effective. Normal mental growth, without deficiency, can be expected in patients cared for as stated above. A special diet should be continued at least until the child enters school.

The frequency of occurrence of this disease is small. In institutions for mentally retarded, one per cent (1%) of the children are handicapped because of this condition. However, we now know how to stop this one kind of mental deficiency. Let us apply our knowledge and save every infant with this condition for a normal life. Let us begin the prevention of mental deficiency by early testing of every infant for phenylketonuria. The cost and effort of finding a case is negligible in comparison to the saving of even one child from the results of this dread disease.

*Executive Secretary, Delaware State Board of Health.

FROM SORE THROAT TO RHEUMATIC HEART DISEASE

● **The physician's and bacteriologist's part in the recognition of rheumatic heart disease is described. The physician may use the public health laboratory to assist in quick diagnosis.**

IRENE V. MAZEIKA, M.D.*

The human throat is a "golden gate" of entrance to innumerable and invisible invaders: bacteria, viruses, fungi, ova or larval forms of intestinal parasites and cystic forms of intestinal protozoa. They may differ greatly in their kind, size and pathogenicity. Many of them by-pass the throat and in ways typical to each one of them, seek the organs of their choice. Others stay in the throat and form its normal or pathogenic flora.

A throat flora may be considered normal when the primary culture on the blood-agar plate shows a predominance of alpha (greening) Streptococci or nonpathogenic Neisseria (Gram-negative diplococci); while others like staphilococci, pneumococci, Hemophilus (influenzae or hemolyticus), diphtheroids, gamma (no change on blood-agar- Streptococci or hemolytic Streptococci other than group A, do not appear in significant numbers. A rather unusual finding in the throat culture are coliform bacilli, which may predominate after penicillin treatment.

On the other hand, the primary throat culture showing growth of beta hemolytic Streptococci (complete hemolysis of the red blood cells of the medium) or the predominance of microorganisms other than alpha Streptococci or nonpathogenic Neisseria, should be carefully subcultured, "fishing" suspicious colonies and inoculating them on the new blood-agar plate.

Other Important Micro-organisms

Besides beta hemolytic Streptococci there are several etiologically important microorganisms which may be found in a sore throat. They are: Corynebacterium diph-

*Assistant Director of Laboratories, Delaware State Board of Health.

theriae (in carriers the cultures are not always successful, so several consecutive cultures should be made), spirochetes and Fusobacterium of Vincent's angina, pneumococci (especially in children who swallow their sputum), meningococci which have to be checked in a naso-pharyngeal culture too, and Hemophilus (Bordetella) pertussis. The identity of all these bacteria have to be definitely proven and immediately reported.

The beta hemolytic Streptococcus, which is one of the most important representatives of the pathogenic throat flora, is causing many diseases of clinical character. They may be divided into two different groups:

1. *Suppurative diseases*: adenitis, arthritis, cellulitis, enteritis, empyema, erysipelas, impetigo, lymphangitis, meningitis, osteomyelitis, otitis, periostitis, peritonsillar abscess, peritonitis, pneumonia, puerperal sepsis and septic sore throat.
2. *Nonsuppurative diseases*: acute glomerulonephritis, scarlet fever and rheumatic fever.

A Disease Of The Young

Rheumatic fever, being a disease of young age, merits special attention. It is disastrous in its consequences, killing or crippling more children and young people than any other disease. Rheumatic fever is the first cause of death in the age group 10-15. In clinics about 93 per cent of all heart disease in patients under 20 years of age is of rheumatic origin.

In adults, the first attack of rheumatic fever is usually short and involves the joints rather than the heart; and if the heart is involved, the rheumatic process is seldom grave.

The observations of rheumatic patients and research done in the last 20 years have established that there are several predisposing factors to the disease.

Race does not play any part in the susceptibility to rheumatic fever, although Chinese seem to be slightly more resistant.

Sex plays no part either, although women appear to be slightly more susceptible.

Climate seems to be one the important factors. The temperate zone, especially its colder and humid regions, is certainly favoring rheumatic fever infection.

Resistance of the individual has some influence on the susceptibility; asthenics and children with constitutionally poorer mesenchymatous tissue are more prone to develop the disease.

Family incidence has, without any doubt, an important role. About half of the patients with rehumatic fever infection, rheumatic heart disease or chorea, have relatives with a history of similar ailments. The cause of this phenomenon is probably not only inherited susceptibility to the condition, but also contact with the members of the family, who have an acute or chronic streptococcal throat.

Definite Tie-ins

The social, economic and occupational status is of definite significance. Unsanitary and crowded quarters, cold, draft, humidity, poor clothing, undernourishment and fatigue seem to influence rheumatic fever infection. In the smaller, better provided private schools, the incidence of rheumatic fever is not significant, while in the large, crowded public schools, it is rather common. No wonder then, that in such surroundings as schools, hospitals, factories and armies (especially in the first year of service), the streptococcal sore throat infection may spread with alarming speed and be followed by an epidemic of rheumatic fever. The rheumatic process in adults is influenced significantly by occupation. People doing strenuous work in cold and humid weather or in drafty, hot or cold places, are attacked more easily, usually in the extremities.

Any sore throat in school-age children should be given the most serious attention. The medical service in the schools could well be supplied with sterile swabs and maintenance media for shipping them. The school medical authorities should be instructed to take material from each acute

sore throat and send it immediately to the nearest bacteriology laboratory.

Usually young rheumatic fever patients have a history of several sore throats. The group A beta hemolytic Streptococcus, although firmly established in the throat of its victim, is not able to provoke a rheumatic fever attack at once. Its toxins, eliminated into the circulation gradually sensitize certain mesenchymatous tissues to the point of an acute allergic status.

Symptoms Of Rheumatic Fever

Rheumatic fever starts with several general symptoms like increased temperature, rather excessive sweating, loss of weight, pallor, anorexia, leukocytosis and increased blood sedimentation. The site and the intensity of the symptoms seem to be influenced by the virulence of the Streptococcus and the resistance of the patient. Swollen joints, usually the large ones and usually in pairs, are red, hot and tender but not infected.

The local symptoms of the acute rheumatic fever process in the heart are rather elusive. especially in the first stage of the illness. They are limited to precordial discomfort or nontypical, sometimes sharp, pains in the chest. There may be some changes in the rhythm of the heart such as: premature beats or paroxysmal tachycardia. More or less pronounced dyspnea results usually from acute pericarditis or acute cardiac dilatation. In mild cases like rheumatic sore throat, symptoms of cardiac involvement are seldom detected.

Rheumatic Heart Disease

Rheumatic heart disease starts as a diffuse, degenerative edema, which in the second week of the illness (or later), develops into a characteristic inflammatory process around the blood vessels and within their walls. It develops gradually into lesions typical of rheumatic sensitization such as granulomata. These granulomata, called Aschoff bodies, may also be found in the heart muscle (between its fibers) as well as in the endocardium, pericardium and nerve fibers. In the progress of the illness they may subside and finally disappear completely. However, in about 15% of chronic cases they tend to remain.

In rheumatic fever, the heart muscle is damaged not only by the typical rheumatic lesions, but also by malnutrition, caused by infiltration and degeneration of the walls of the coronary vessels. The rheumatic process of the myocardium may provoke heart dilatation, which in turn, may lead to heart failure and death. Heart failure in the chronic rheumatic heart may be caused by a recurrent attack of rheumatic fever. On the EKG, the earliest and only sign may be prolongation of the P-R interval, due to edema or Aschoff bodies pressing upon the conduction system. In serious cases there may be dropped beats, omission of the whole cycle and even heart block.

Rheumatic Endocarditis

In rheumatic endocarditis, the typical lesions in the form of tiny vegetations appear usually on the auricular surface of the mitral and tricuspid valve cusps or on the ventricular surface of the semilunar valve cusps. Their size may extend from a tiny, almost undetectable nodule to 2-3 mm. in size. They are formed mostly on the line of closure of the valve, exceptionally within the valve itself. Later when the primary edema subsides, the exfoliated epithelium is substituted by new connective tissue which finally develops into a scar. The scar may fuse the edges of the valves thus forming stenosis or it may shrink them, causing insufficiency. The highest percentage of rheumatic lesions are located on the mitral valve (62-80%). The tricuspid valve is seldom affected; and still less the semilunar valves.

Rheumatic Pericarditis

Rheumatic pericarditis, starting with edema and exfoliation of the epithelium, may cause an exudative process with the accumulation of the fluid in the pericardial sac. The resulting formation of adhesions between the visceral and parietal layers of the pericardium leads to adhesive pericar-

ditis and to its frequent sequela, Pick's disease (pseudocirrhosis of the liver).

The first infection may be mild and does not necessarily result in a serious damage to the heart, but there always exists a danger of recurrent attacks. There may be several attacks, each one of them aggravating the status of the patient. However, in adult life, a recurrent attack is rare. Sometimes an irreparably damaged heart may succumb to the following: (1) auricular fibrillation which complicates about 70% of the cases of mitral stenosis and 20% of all cases of rehumatic heart disease; (2) congestive heart failure (myocardial insufficiency) which complicates about 70% of all cases of rheumatic fever; and (3) subacute bacterial endocarditis (infected by alpha, greening Streptococcus) which complicates 5-25% of all rheumatic heart disease. A recurrent attack may be brought on not only by a new infection with Streptococci or by any other bacteria, but also by some circumstance such as chilling, fatigue or injury.

Fortunate Cases Of Complete Recovery

Sometimes when the damage of the heart is not crippling and the patient has good medical guidance, he may enjoy a long and active life and finally die of some other disease. There are fortunate cases in which the rheumatic process subsides completely and the heart returns to normal.

Opinions about the therapy in the rheumatic fever infection are many and varied; but Dr. Paul D. White's belief is that "good nursing care" is of prime importance and is worth more than most drugs. The improvement of the patient's status after salicylate therapy is ascribed rather to the result of decreasing streptococcal throat flora than to restraint of rheumatic fever.

Local Therapy Important

Considering that it is *the throat* which is the site of the growth of group A beta hemolytic Streptococci and that the toxins of this Streptococcus cause the alergic rheumatic fever sensitization, it seems logical to apply also energetic local therapy in the form of gargles, swabbings and vaporizations. If the tonsils are infected they should be treated conservatively. The surgical removal of tonsils does not decrease the menace of a recurrent attack or the severity of a new rheumatic infection. It does not even change the status of allergic sensitization. It is important to eliminate streptococcal infection *in situ* and thus cut off the supply of bacterial toxins sensitizing the susceptible tissues. Numerous examples show that in spite of prolonged and intensive general treatment, group A beta hemolytic Streptococci are found repeatedly in the throats of convalescent children. In cases clinically suspected of being rheumatic fever, the throat culture should be made promptly and attention should be focused on the beta hemolytic Streptococcus. It is essential to prove that any hemolytic Streptococcus belongs to the serologic group A, because the etiologic relationship of group A and the clinical or subclinical form of rheumatic fever has been definitely established.

The Role Of The Bacteriological Laboratory

The responsibility for proving or disproving a diagnosis of rheumatic fever is finally taken over by the bacteriological laboratory. Your public health laboratory can furnish you information and containers for the submission of specimens for examination. Special culture methods and other tests are possible. The use of the new Fluorescent Antibody Technique for diagnosis should be used where possible. It is a quick procedure that gives a prompt and fairly reliable result. If group A hemolytic Streptococci can be identified within a few hours, we have open to us new horizons in the control of this treacherous disease.

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PUBLIC HEALTH AND

Modern practice of medical and social science today has resulted in aiding people to reach the expression of a universal ambition. Fundamentally, this ambition is the wish to live a longer, healthier, more fully effective life.

National awareness of the fact that people are living longer and demanding to continue their useful productive lives finds expression in almost every type of medico-social literature released during the past and present decade. It has become apparent that the older population and that portion of the population approaching older age, present a new complex of medico-social problems. In the light of this awareness, official and voluntary health and welfare agencies are investing and directing a large portion of their professional energies toward attempts to more effectively serve the needs of an aging population. Older adults and the voting power they represent constitute a formidable power to be reckoned with.

This age group can no longer be thought of as a minority group representing problems and demanding services which organized medicine and organized public health can afford to dismiss. A constructive, workable program, to meet the needs of older adults for preventive medical services, must be developed by organized medicine and organized public health. If this is not done, then others less qualified to do so, will accept this responsibility by default.

The purpose and philosophy of organized public health in this area would be essentially the same as in other preventive medical endeavors, namely, the evaluation of the older person's total situation and, based upon professional experience and judgement in this area, channel back to private medical resources the disposition of those problems amenable to private medical solution. As such, a preventive geriatric program would serve as comprehensive service for the purpose of fulfilling the objectives of public health and to expedite private medical care.

Organized medicine, too, is faced with an increasing dilemma. It can continue to invest its energies in a futile attempt to block provision of services which would exploit political potentials or lend its support to

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● Modern medicine and public health have succeeded in adding years to life. We are now challenged to accept the responsibility of adding breadth and depth to these added years.

PREVENTIVE GERIATRICS

EDWARD F. GLIWA, M.D.*
MARK KENYON, PH.D.**

agencies which have traditionally functioned and will continue to function to expedite the private practice of preventive medicine.

The dynamics of the present situation do not appear to be diminishing. It is increasing by virtue of subtle and, at times, direct pressure to institute legislation which would serve to the detriment of the older adult, organized medicine and organized public health programming.

Program Outlined For Delaware

Workable, practical systems whereby the needs of older people may be determined and reasonably served must be developed by official health agencies as both a community service and as an aid to expedite the private practice of preventive medicine. This paper presents a possible program outline to deal with the medico-social needs of Delaware's aging population. It is not intended to blueprint a final approach to so complex a field. The authors hope only to present a practical outline, or guide, which could serve as a justifiable beginning.

The basic aim of this program would be to develop a central study service or evaluation center or clearing house primarily for people who are over the age of 60 and who require aid in meeting their medico-social problems and other problems arising from them. It would be a unified attempt to provide a complete evaluation of a person's needs in one place rather than a piecemeal multiple stop type of service. The service would be staffed by a team composed of a director of adult counseling services. In addition, medical and social service personnel would be needed to make an initial appraisal of the needs of patients and determine their amiability to medical guidance, treatment, and to the social services currently available in the community. Accumulating evidence tends to show that older people do not make full use of the health and social services available to them. An important emphasis in this type program would be to devise ways of overcoming resistance and reluctance to utilize available services. The physical presence and potential availability of physicians and hospitals in a community does not insure that they will be adequately used.

Servicing the ambulatory older person living in the community is a compartively new field. Nevertheless, adequate justifica-

tion of such proposed programming resides in the fact that it is expandable and flexible. The investment in physical plant, time, and finances would not be excessive. There are many ways to justify a program of health maintenance or preventive medicine. The underlying principles and the proven good judgement of any preventive medical and public health program apply with equal import here. The moral justification ante dates the medical and public health professions. Evidence can be found in scriptures, "You shall rise up before the hoary head, and honor the face of an old man" (Lev. 19:32); "With the aged there is wisdom and in length of days there is understanding" (Job 12:12). Those of us preferring a more materialistic justification cannot argue against the known fact that an ounce of prevention against social, financial, and physical deterioration is worth more than a pound of cure.

Modern Society Often Responsible For Problems Of Older People

Modern American society in many ways contributes to the problems of older people. Certainly no single program can be expected to counteract all negative influences. The heavy emphasis placed upon gainful employment, being youthful and attractive, being independent, etc., often leaves the older person quite handicapped, even though he may have heretofore led a productive and well adjusted life. One basic aim would be to help the older person utilize his own personal, and the community's resources, to counteract tendencies toward debilitation and, in some cases, gross deterioration.

A preventive service such as is discussed cannot be a "fountain of youth" but rather may have to be satisfied with less spectacular gains. Each older individual's progress would be measured as a function of change, from their own base line as well as actual prevention or amelioration of debilitating disorders. The population which the service would attempt to reach would be persons over the age of 60. The only provision would be that they be sufficiently ambulatory to be seen at the centers set up within existing county health units. Transportation, utilizing other community resources, could be enlisted to bring persons to the service.

The question arises as to whether aged persons would avail themselves of such service. This problem was explored in the cross-sectional survey conducted at the Kips-Bay Health Center in New York City. Respondents were asked: "If this neighborhood had a medical center especially for older people, would you go there for advice on your health problems?" Sixty-two percent replied that they would, 31 percent that they would not, and 7 percent did not know. Of every 10 respondents in each economic group, 2 in the high group, 6 in the medium group, and 7 in the low-income group would use the service. This center serves approximately 160.000 persons. The results of an analysis of 250 cases indicate that, especially with the lower income group, a definite need is felt for help specifically directed toward older people in a wide range of problems. It is anticipated that considerable numbers of patients would be self-referred.

Interaction Between Health Services And Other Community Agencies

One objective of this service for the aging would be to channelize individuals to resources in the community where they could receive ameliorative help with specific non-medical problems. Rather than develop an extensive program which might duplicate existing facilities, the program would pro vide further information about the adaptability of certain kinds of services, as now constituted, in helping the aging.

The proposed service should attract considerable numbers of aging persons. Provision would be made to avoid the possibility of "flooding" referred agencies. The goal of the proposed service would be to screen and refer older persons for service in accordance with the extent and variety of facilities that are found in community agencies and to determine the extent to

which such referrals are successfully employed.

""The physician in private practice may not have time to concern himself directly with all the many problems arising from problems associated with aging, but he should, as a good citizen lend his support to the marshalling of forces which can deal with them. For example, none knows better than he the importance of maintaining the previous environment of the aging person, leaving about him those things to which he is accustomed; those tools of living which he has already learned to use; those relatives, friends and acquaintances whom he has known most of his life. These elementary principles of geriatric medicine are matters of prime importance in the application of our social security laws; essential to the success of communal housing projects; necessary for the individual's development and maintenance of satisfying and productive interests and activities. Many disciplines are needed to effect the solution of these problems."*

Referrals To Other Agencies

It is important to specify that any service so planned would make the decision to refer a patient to an outside agency or clinic only if such intensive work seems indicated by analysis of the patient's problem and situation. Wherever such analysis indicates that the individual is likely to benefit from services available in other agencies, referral to such agencies would be made. Referrals to community social and health agencies would be geared to the intake policies and service facilities of each agency. Acceptance of referrals from other agencies will be limited by the optimal intake load and the facilities offered by the service.

Essentially, a "preventive geriatric" service would provide a short-term relationship with the older person but will also entail follow-up contact with agencies to whom they might be referred. The type of services that would be provided would be: Information and health education, socio-medical workup and evaluation, referral to appropriate community resources, financial, employment, family agencies, recreation and utilization of leisure time, living arrangements and housing.

*"Care of the Aged"—Thomas Hodge McGavack, World Wide Abstracts—June 1960, Vol. 3, No. 6.

To live long, and age happily is a fundamental human desire. A long life need not be accompanied by physical disease and social maladjustment. Senescence and senility are not synonymous. Aging and chronic illness are often synonymous in the minds of most people. Aging is a process not a disease and it is not necessarily accompanied by any specific disorder.

Positive Guidance

A good portion of the potential to live a long and useful life depends upon positive guidance which enables older people to live in reasonable security and satisfaction. As such the characteristics of the aging process deal with those phenomena which are as peculiar to it as teething is at an earlier epoch of life. Aging differs from earlier periods of life only in the degree to which it represents economic, social, educational, financial, as well as health and medical problems, and the necessary adjustments in each of these areas.

In view of the fact that older adults constitute an increasing segment of our population, and that this segment will continue to increase, it is necessary to give serious consideration to developing a more positive philosophy as to the role of the aging in the total society.

New Concept Of Aging

The concept of aging gradually being outgrown is based upon a general assumption of organic and bio-social deterioration starting during middle life, and progressing until it finally becomes irreversibly incapacitating. The result of such misinformation has been to expect little or nothing. The roots of the present philosophy can be traced by examining the economic and industrial history of the nation.

As a consequence of the overemphasis upon youth, the first adaptation to aging was to set older people apart from the rest of society. They were considered as a group no longer useful, having made what contribution they could, and as such entitled to withdraw to enjoy the "leisure"

of their remaining years. In many activities, older persons have been encouraged to give way to youth. This point of view has often been idiomatically expressed in the phrase, "youth must be served." A more positive contention would be, both youth and the aged must be served.

The organic and social characteristics of aging are usually gradual; they do not cause sudden inability to deal effectively with life situations. It follows that a concept of aging, based upon gradual decline in faculties will slowly be assimilated. Attainment of middle age should be viewed as the threshold of a new epoch of life; an epoch that can represent a new stage of adjustment, maturity, and social contribution. The older adult who is free from the immediate responsibilities of early adulthood, can make new contributions to the general welfare. Experience gained as a result of having lived a half-century or more would tend to make the contribution of older persons to the social welfare more effective. This is the role older persons would choose for themselves.

Science Of Gerontology

The science of Gerontology is concerned with the investigation of the many physiological, psychological, and environmental factors which affect and influence the aging process. It is also concerned with investigation of methods and techniques which tend to maintain and improve the health and well being of the older adult. It utilizes health education, and educational methodology as a positive approach toward these desirable goals. Gerontologists and other health and welfare specialists have considerable information which if properly applied, would markedly improve the health, economic status, and general welfare of older adults.

The fundamental principle of public health endeavors is prevention of disease and debilitation. The application of this underlying principle has paralleled the emphasis placed upon youth in our culture. Prevention of communicable disease is a foundation of public health. This is exemplified by the development and application of sanitary science, environmental health programming, and the control of food and water-borne disease. Public health, together with other branches of medicine, stands on the threshold of the new challenge resulting from its past successes. This new challenge is one of chronic disease and the problems arising therefrom. Public health has also been consistently concerned with the maintainence and potential improvement of the individual's health. One can parallel all these past and present philosophies by tangible public health services. The well child conference is an example of utilizing modern technique for maintaining and promoting the health of the child. This is done by utilizing the team approach of medicine, nursing, nutrition counseling and health education. A similar parallel is presently lacking for the older adult.

Health Education Programs

The objectives of health educational programs are two fold; the first being improvement of the educational process applied to aging persons, and secondly; the application of accurate information and procedures to improve and maintain both personal and community health. Health education endeavors to develop a sense of responsibility and provide the indispensable motivation for the preservation and improvement of personal and community health.

An effective health educational process must possess meaningful information and sufficient motivation. Such motivation to develop desirable attitudes leading to constructive action on the part of the individual are effectively accomplished within the physician-patient relationship. This relationship would be utilized in the evaluation center.

A second consideration of equal importance regards the position of respect and status represented by the medical profession and its practicing members. Guidance and counseling which result from the health

appraisal is held in high regard by the patient. The word "doctor" itself is derived from the Latin, doceo, meaning to teach.

The steady increase in demand for medical care is a tribute to the effectiveness of community health education techniques and the quality of present day medical practice. The possibilities for including health education as part of medical service and general community education to prepare for later maturity and aging is unlimited. It must begin long before "retirement age." Therefore, geriatric service has three distinct objectives: first, the postponement of senility; secondly, treatment when necessary; and third, lifelong coaching, guidance and counseling.

Early Education Urged

The sooner health education for aging is applied, the greater the benefits to the individual. The values derived from early education for aging are infinitely greater when applied at age 40 than at age 60.

The focus and philosophy of a service for the aging reflects the gradual change in emphasis which characterized health and welfare services at the turn of the century. Service and programs were developed to do things "to people." Later on emphasis changed to doing things "for" people. At present, maximum effort is devoted to doing things "with" people while the two previous points of view are utilized depending upon individual situations.

Increased medical skills and newer therapies have succeeded in prolonging human life to the extent where problems previously non-existant became acute. The rapidly expanding and progressive advancement of medical science have paralleled similar advancement within the social sciences. Older persons are at last being considered as individuals living in family constellations wherein social and interpersonal dynamics are in continuous operation.

The inter-relationships between individuals, families, and communities should serve as criteria upon which programs and services are evolved. Previously, persons were thought of as exponents of some organic entity unrelated to the physical, cultural, and emotional environment. The obvious inadequacy of this point of view, resulted in evolution of a new philosophy which conceives of the individual as a product of a bio-social past, interacting with the physical, social, and emotional environment of the present. This newer concept of man is still in process of evolution.

Modern medicine has successfully controlled, treated, and prevented many of the major causes of death and debilitation. This progress has changed the focus of the problems associated with aging from one which previously had been medical with social implications, to one of major socio-economic importance with medical implications.

Assessment Centers Called For

The 1951 Governor's Conference on the Problems of the Aged in the State of California called for the establishment of "assessment centers" on a local level as a desirable and critically needed part of the medical care organization for an aging population.

""*The centers could be located at existing in-patient or out-patient departments of hospitals, at private medical clinics, at health departments, or within industrial medical services. These assessment centers would be primarily advisory, and would provide facilities for counseling, diagnosis, and social service, and by reference to specialists and treatment facilities would aim to establish the maximum rehabilitation of the individual.*"

The 1960 Governor's Conference on Aging in Delaware also cited this need.

Another overall objective of a service program for the aging is preparation for normal healthy aging, and the control of chronic illness. This would follow a pattern of local administration and implimentation of needed health and welfare services. Chronic disease control programs in public health have long been justified. Mr. Oscar Ewing proposed that:

1. The basic approach to the conquest of chronic disease must be prevention.

*Governors Conference on the Problems of the Aged, Sacramento, California, 1951, p. 152.

2. The emphasis for victims of these diseases must be on arresting the progress of the ailment and on helping the individual to maintain normal living.

3. The emphasis for the medical and public health professions, business, industry, and the general public must be on the capacities and abilities of the victims of chronic diseases, rather than upon their limitations.

Emphasis May Swing To Age

Emphasis upon youth which so characterized our nation in the past, will in time be properly apportioned to include and appropriately value the human resources of our older adults. Human life has been extended. It has been given additional length. We are now challenged to give it breadth and depth.

States should encourage and support establishing all-purpose facilities for counseling, for early detection and follow-up of diseases and disability, and for promotion of public health education in nutrition, and mental health.

Many persons are being restored to productive lives through rehabilitation programs in geriatric centers associated with general and mental hospitals. These centers are staffed by general practitioners, psychiatrists, social workers, nurses and other persons experienced in working with the aging. Another aim in this field is prevention of mental disease and the maintenance of mental health.

Prevention calls for a comprehensive program which emphasizes and makes available community mental health services and education when they are needed.

State Agencies Available

State agencies that could be made ready for service include the State Department of Public Welfare, the Rehabilitation Division of the State Board of Education and the State Board of Health. The best way America's 16 million senior citizens can be helped adequately is in the family, if possible, and in the community. The best assistance we can give is to help the aged help themselves.

The central problem of the aged group is not any one specific concern such as health, employment, or finances, but rather that of maintaining or rediscovering a meaningful and significant role in life, either within the family or in the community. Predisposition to use community resources will vary with age, socio-economic status, ethnic group, and health. The first step should be to provide the help needed now.

SUMMARY

The major functions of the proposed service would be:

1. To serve as a screening center for older adults who need help in some area and do not have knowledge of existing resources.

2. To serve as a study and evaluation center to give definitive advice to older adults or the agency referring the person to the center, regarding possible disposition.

3. To provide a direct service whose function will be to counsel older persons toward the possible solution of their health and other problems and those circumstances which prevent their adequate adjustment.

4. To help maintain the optimum physical and mental health possible and prevent unnecessary breakdown.

5. To help older persons to attain and experience the satisfaction of three basic needs, namely: Something to do. Someone to care. Some place to live in dignity, health and independence as long as possible.

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DISCIPLINE

AS A PHILOSOPHY OF LIVING

● **Discipline is a method of influencing behavior. A child is taught not only what he has to do, but also what he is prohibited from doing.**

FRED A. STONESIFER, PH.D*

One of the most pressing concerns of mothers with young children is exemplified in the following query: "What shall I do when Johnny—?" This question might be directed to members of the bridge club, the neighbor across the back fence, the man at the store, or some professional adviser. While there is always the possibility that the mother is making conversation, the professional consultant would do well to regard such requests seriously, at least until further information reveals the extent of the mother's concern. An offhand or superficial reply may later reveal to the consultant that he has put himself in a difficult position, especially if the mother returns and says, "I tried what you said, but it didn't work. What do I do now?"

The Meaning Of The Word

The problem of discipline is one which all parents have to face. The difficulty of dealing with such a problem is complicated by the variety of meanings which the word discipline presents. A casual reference to an ordinary dictionary will reveal a dozen or more meanings of the word. Some of the concepts in the definition are the following: training, subjection, instruction, exercise, habit of obedience, punishment, correction, chastisement, a system of rules, a method of practice, studies in a course of learning, self-scourging. In further defining some of these words, we come upon such references as: to chasten, to subdue, to moderate, to restrain, to penalize, to requite, to educate, to develop the natural power and shape character by, to impart knowledge to, to give instruction to, to teach, to train by practice, to learn, to ascertain, to acquire skill, to make obedient to. From this partial list of meanings and concepts, it is easy to point out the difficulty of undertanding exactly what is meant by the person who seeks help because she has a problem of discipline.

For purposes of this paper, discipline will be considered as a systematic method of influencing behavior. Such a definition would include not only those instances where the parent is dissatisfied with the youngster's behavior in certain situations, but would also include those positive aspects of the child's development which are agreeable to the parent and include a compliance with social rules and customs. A more

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formal statement which seems to imply the same meaning is that of Ausubel,[1] which "refers to the imposition of standards and controls by others on the child's behavior." He goes on to explain his point of view under the term democratic discipline. This preferred method is contrasted with the laissez-faire method of under-domination of the child and the authoritarianism of over-domination.

Discipline Works Both Ways

In considering the problem of the child's behavior, it must be kept in mind that this whole matter is not a one-way process. It might appear to be so because the parent always brings the child's behavior to the attention of the consultant. The process is never reversed. Yet the parent is the one who is teaching the child constantly how he is to behave and also is the model for the concepts being presented. It would appear then that if there are any concerns about the child's behavior, the parent as well as the child should be studied in relation to the total situation. Allowing for an appropriate period of training and learning, the reasonably healthy child can be expected to behave the way the parent has taught him.

The point of view of this writer is that all behavior is learned behavior. It is an adaptation of the individual to his needs and to his environment. His adjustment to his life may be agreeable or not, both to himself and to others. Whether or not satisfactions finally are developed and produced, depends upon how the individual learns to adjust himself to the needs and pressures that surround him. The role of the parent, the family, and society is to help the individual achieve the kind of adaptation and adjustment to the life he must lead so that he can develop into a competent, efficient, happy, and productive, mature member of society.

If behavior is a matter of learning, then it is also modifiable. When the parent is so concerned about the child's behavior that help outside the family is sought, the supposition is that either the parent's methods of dealing with the child should be changed or improved, or else some change must be brought about in the child himself. The probability is high that changes in both parent and child are necessary. Interacting forces and relationships are involved here so that the change in one instance results in a change in the other part of the common problem. This is not a matter of doing something to the child or to the parent, but rather an awareness of how a particular problem is being handled, of clarifying the parent's goals, and of helping to develop insight into methods of achieving the desired effects.

A Guide To The Positive Approach To Living

The ways to help a parent achieve the goals towards which she directs the child might seem difficult and indeed are at times. On the other hand, all acts of living might be considered as part of the disciplinary process to which everyone is subject. One's own point of view is involved here. The values and satisfactions that each one develops have a great deal to do with how the strain of ordinary daily life is met. A healthy and positive approach to daily living is not over-simplified in a statement which defines discipline as "directing a child's activities and behavior so that he can enjoy and be enjoyed by, the people around him."[2] As the child matures and develops, the mutual satisfactions of the child and of the people around him, presume that gradually he will be able to take over more and more responsibility for his participation in and management of daily living. The parent will provide an opportunity for practice in making decisions, forming judgments, and establishing self-control on the part of the child until at adulthood he has the capacity for complete responsibility of his own affairs.[3]

The view presented in this paper seems to be a broad one, and to encompass the whole of life's problems. This is admitted. However it is also suggested that many of the most perplexing circumstances with which individuals deal are often of relative

minor importance when viewed as discrete events. Yet as these minor irritations accumulate, the total effect is frequently overwhelming and out of proportion to the particular circumstance. The value of a balanced and stable over-all view of events and situations is evident. Thus it is that the need for a basic point of view, a goal, a philosophy of living, is of primary importance. If the parent has a way of life which is reasonable and provides satisfcation, she will be able to deal with the relatively minor incidents and concerns of daily activity much more effectively, not only as regards her child, but herself also. She will know when she needs information, advice, guidance, counseling, and will seek it, and having sought it, hopefully will use it. To the extent the parent is able to do this, she will help her child to understand what is expected of him and how they may both reach the point of a competent, satisfactory adjustment to the kind of life available to them. Such a mother does not deal with the problems of her child from the standpoint of what is good or what is bad, but rather how and what is the child learning. She does not go about her day's work concerned with the problem of discipline, but rather is interested in and concerned with "the splendid process of learning how to live."[4]

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Contributors Column

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TUBERCULOUS EPIDURAL GRANULOMA OF THE SPINE SIMULATING NEOPLASM

● **Tuberculous granuloma of the extradural space of the spine, when not associated with tuberculosis elsewhere, can easily be confused with malignant disease. The differential diagnosis, therefore, is of paramount importance.**

Report of Two Cases*

RALPH M. MYERSON, M.D.**

Tuberculous granuloma of the extradural space of the spine is generally a sequel of tuberculosis of the spine or of direct extension from a mediastinal or paravertebral tuberculous process. Occasionally there may be no evidence of tuberculosis in the vertebrae or elsewhere in the body. Two such cases associated with a rapidly developing paralegia,, have been seen in this institution. In both instances the clinical, roentgenological and operative findings could not be distinguished from a neoplastic process. One patient had evidence of minimal tuberculous involvement of the spine but neither had evidence of tuberculosis elsewhere in the body.

REPORT OF CASES

Case No. 1

A 27 year old Negro was admitted to the Veterans Administration Hospital, Philadelphia, Pa., on January 21, 1954, with a chief complaint of weakness of the legs. Easy fatigue and mild lumbar pain had begun six months before admission and there had been a progressive weight loss of 20 pounds during this time. One week before entry to the hospital, weakness and progressive ascending numbness of the legs and difficulty in voiding developed.

The past and family histories were negative. Positive physical findings on admission consisted of moderate tenderness to percussion over the fifth to eighth thoracic vertebrae. A spastic paraplegia and loss of all sensory modalities to the level of T7 were present.

Routine hematological studies, blood chemistry and roentgenograms of the chest were within normal limits. A lumbar puncture yielded clear colorless spinal fluid with an initial pressure of 250 mm. of water. No cells were present and spinal fluid chemistries were normal except for a protein of 436 mgm. per 100 ml. The serological test for syphilis was negative and the colloidal gold curve was 0001210000. Roentgenograms of the spine revealed a radiolucent defect in the body of T8 and some loss of stature of this vertebrae (Figure 1).

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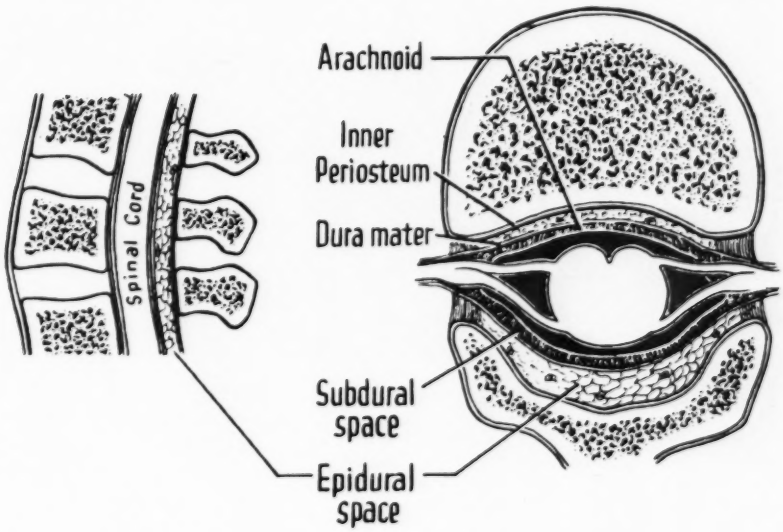

FIGURE 5*

Anatomy of the Epidural Space. The spinal epidural space is bounded by the dura surrounding the cord and by the periosteum of the vertebral canal. It extends from the first cervical to the second sacral segment. An actual space exists posterior to the cord, whereas anteriorly it is only a potential one.

The patient was seen by a neurosurgical consultant and laminectomy was performed from the seventh through the eleventh thoracic vertebrae.

The epidural space in this region was occupied by dense, grayish-white tissue which appeared neoplastic grossly. Removal of all of the abnormal tissue was not feasible. Biopsies were taken and the dural sac was decompressed the entire length of the lesion.

Histologically, a granulomatous type process with giant cell formation was noted (Figure 3). Special stains of the tissue revealed acid fast bacilli and subsequent cultures taken at the time of surgery were positive for M. tuberculosis. Spinal fluid cultures subsequently were reported as negative.

The patient was treated with streptomycin and isonicotinic acid hydrazide and, following his immedate postoperative period, with physical medicine and rehabilitation. Improvement was slow but steady and at the present time the patient has few residuals of his disease.

Case No. 2

A 33 year old Negro was admitted to the Veterans Administration Hospital, Philadelphia, Pa., on May 18, 1958, with a history of weakness and numbness of both lower extremities associated with chills and fever of two weeks duration. There had been a weight loss of 30 pounds in the previous five months. The past and family histories were negative.

Examination on admission revealed a spastic paraplegia with a sensory level corresponding to T6. The remainder of the physical examination was within normal limits. Routine laboratory studies and roentgenograms of the spine and chest were within normal limits. A myelogram revealed a complete block to the dye at the level of T6 (Figure 2). Examination of the

*This illustration is reproduced by permission of the authors (Ref. 3) and the American Journal of Roentgenology, published by Charles C. Thomas, Springfield, Ill., for the American Roentgen Ray Society.

FIGURE 1

Roentgenogram of spine revealing lytic lesion of T8 associated with loss of vertebral stature.

spinal fluid revealed a protein of 300 mgm. per 100 ml., but was otherwise negative. An emergency laminectomy was performed from T1 to T8. The entire epidural space in this area was occupied by dense, grayish-white tissue grossly resembling tumor. As much of the tissue as possible was removed. There was no apparent vertebral involvement. The pathological report was tuberculous granuloma (Figure 4). Special stains of the tissue were positive for acid fast bacilli and cultures ultimately were positive for M. tuberculosis. Treatment with streptomycin, insonicotinic acid hydrazide and physical therapy has resulted in apparent complete recovery. No evidence of tuberculosis has been detected elsewhere in the body.

DISCUSSION

The anatomic relationship of the epidural space are illustrated in Figure 5. The epidural space may be invaded by a variety of disease entities including acute infections, neoplasms and chronic proliferative processes, the so-called epidural "granulomas." The latter have been reported secondary to tuberculosis, chronic pyogenic infections, foreign bodies, syphilis, fungus and parasitic infestations and sarcoidosis.[1-4] Any of these lesions may give rise to neurological complications.

The acuity of onset, toxic symptoms, history of precedent trauma or infection, and the presence of more definitive localizing signs such as heat and tenderness usually aid in the diagnosis of an acute epidural abscess. There are, however, usually no clear-cut clinical, roentgenological or cerebrospinal fluid findings that help differentiate the compressive symptoms of the various granulomatous lesions and neoplasms. The presence of an obvious process elsewhere in the body will of course tend to focus attention on a similar epidural lesion. An exact diagnosis, however, usually depends upon surgical exploration and microscopic

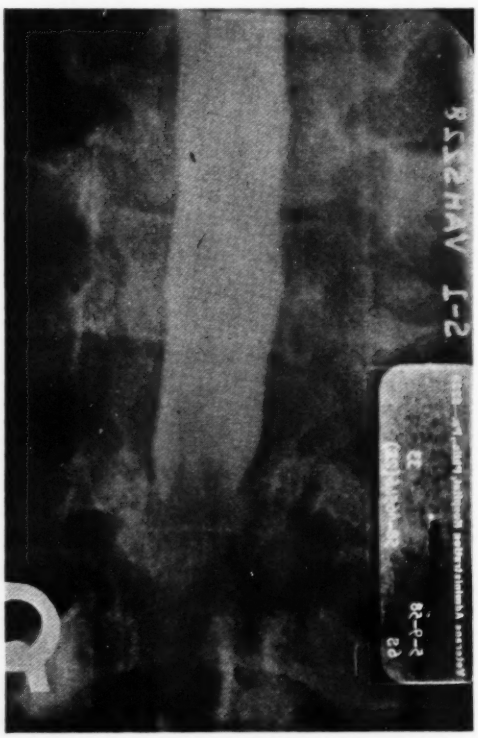

FIGURE 2

Myelogram of case No. 2 revealing complete block at level T6.

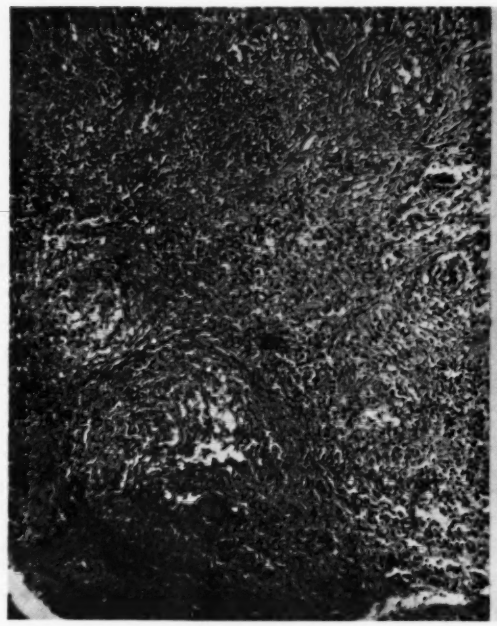

FIGURE 3

Photomicrograph of Epidural lesion, (X90), Case No. 1, showing caseataing granuloma and giant cell formation.

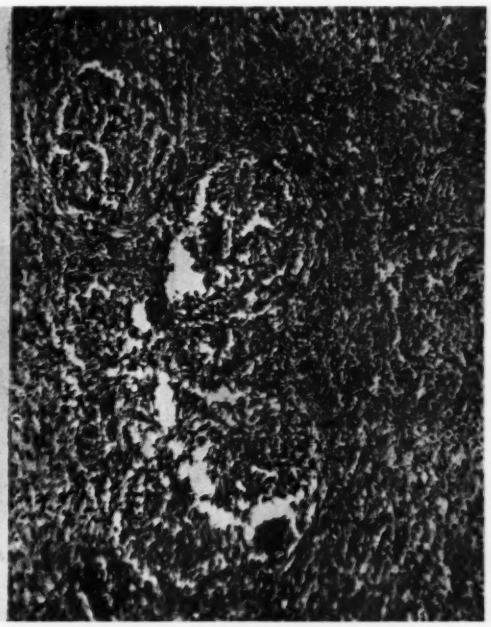

FIGURE 4

Photomicrograph of Epidural lesion, (X90), Case No. 2, showing caseating granuloma and giant cell formation.

and special examinations of the tissue removed. Gross examination may be misleading as in the two cases presented. The granulomas themselves offer differential diagnostic problems even when examined microscopically; even with the use of special staining and cultural techniques no definite diagnosis may be established.

Shenkin and his coworkers analyzed a series of 54 extradural compressive lesions and reported that metastic malignancy was responsible for about fifty per cent. Twenty-five per cent were due to infections, 15 per cent to primary epidural tumors and the remainder were related to congenital cysts, lymphomas and post-traumatic conditions.[5]

Tuberculosis is the most common infectious process producing epidural granuloma. As mentioned previously, the vast majority of these cases occur as extension from Pott's disease of the spine.[6] Primary tuberculoma of the spine is rare. Wilson and his associates found 80 cases of tuberculoma of the central nervous system in approximately 6000 autopsies performed at the Philadelphia General Hospital between 1925 and 1940.[7] There were only 8 cases in which the only tuberculous focus discovered at autopsy was the central nervous system and in only two instances was the process confined to the spinal cord.

The difficulty in establishing a definitive diagnosis and the urgent need for spinal decompression re-emphasize the need for surgery both for diagnostic and therapeutic purposes.

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THE PUBLIC HEALTH NURSE AND THE RETARDED CHILD

● The public health nurse plays her part in the over-all picture of care for the retarded child.

ELEANOR K. BELFINT, R.N.*
LOUISE W. SYLVESTER, R.N.**

The public health nurse has traditionally functioned as a teacher in matters of health. In recent years this area of teaching has been extended to recognition of problems or deviations from normal growth and developmental problems. The public health nurse is often one of the first professional individuals to notice the deviation of a preschool child in terms of normal growth and development. Home visiting provides an excellent opportunity for the public health nurse to observe children who may not be functioning at a normal level. The difference may be reported to the public health nurse by the parent or the parent may suspect a difference and talk about it to the nurse.

Among the terms used to describe deviations from a recognized norm, have been *exceptional, mental defective*, and *mentally deficient*. Today the term that usually is used to describe such conditions is mental retardation. This implies a mental defect and a social inadequacy based upon the inability of the individual to functon satisfactorily in his surroundings.

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As a case finder the public health nurse is interested in the early detection of the problems of the mentally retarded child. She can help these parents to understand that these children have problems similar to those of a normal child. Their physical and emotional wants are the same as those of any child although their rate of growth and development is slower. To this relatively new field the public health nurse, through here training and knowledge of growth and development of normal children, is prepared to understand the growth and development of the retarded child.

The public health nurse helps these parents of a mentally retarded child through her understanding, teaching, and counseling. Parents are sometimes told by their doctor as soon as the condition is evident; others are not told until they learn something is wrong. The first reaction of many parents, when told, is disbelief. This is a normal reaction. Some parents in trying to solve their problems become frustrated and confused. Not until the parents accept the child as a mental retardate can provisions be made to help them.

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1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

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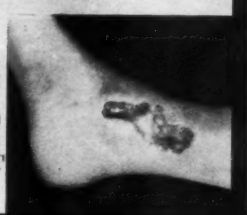
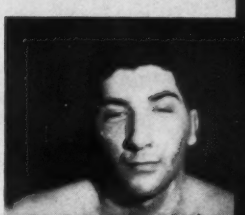
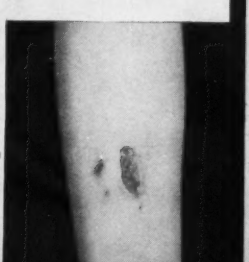
FORCE INJURY
severe bruises
... swelling
... cleared
by fifth day[2]



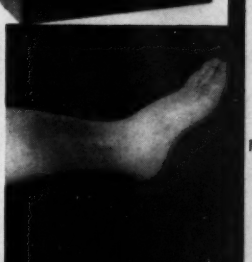
VARICOSE
ULCER
15 years duration
... resolved with
VARIDASE[1]



INFLAMMATORY
DERMATOSIS
rapidly spreading
rhus dermatitis
healed within
a week[1]



INFECTED
LACERATION
marked reversal
in 3 days...
returned
to school...
closure advanced[1]



THROMBOPHLEBITIS
back on his feet
in a week after
recurrent episode[1]

REFRACTORY
CELLULITIS
normal routine
resumed after 4 days
of VARIDASE[1]

In the home, the public health nurse establishes a good working relationship with the family and the child through a warm and friendly attitude. She listens well to the many problems, fears, and concerns that disturb them and because of her supportive and professional role, they gain confidence in her ability to help them.

The mother often needs reassurance and confidence in herself. She is helped to understand that each child is an individual and sets his own pace. He needs daily planning that fits best into his own family life. When simple tasks are demonstrated to the child and attempted repeatedly by the professional person, the parent understands that accomplishment comes only with patience, repetition, and when the child is ready. Understanding this, the parent tends not to blame herself for incompetence, and thus feeling less guilty and frustrated she is better able to help the child. She becomes alert to his readiness for the next step in achievement and independence and is therefore careful not to push him beyond his capabilities.

The pressures of every day living and the demands of other members of the family may limit the amount of time and attention that can be given to the retarded child. Each parent must determine where his time and effort can best be spent for the welfare of the whole family. Similarly, each parent must determine for himself and the child, a plan whereby the child can reach his maximum potential, whether it be at home or by using other community resources.

Delaware's Day Care Centers

In Delaware we have the Day Care Centers for the severely retarded, the Opportunity School for the trainable, and the Hospital for the Mentally Retarded at Stockley for those requiring institutional care. The educable mentally retarded child may profit little from regular school; but in special classes he may be able to learn some elementary or even higher academic and vocational skills. Parents are furnished with information regarding these facilities and urged to visit these places before making a final decision.

It is also stressed that the love and sense of belonging that goes with home and family life will benefit the child in early years in his adjustment to any future plan. Some children may profit from residential living away from home while others may benefit from care and schooling at home. No matter where the child is living he has a right to the love and interest of his family.

Clinical Appraisal Necessary

The only satisfactory detection of mental deficiency is based on a comprehensive clinical appraisal. This appraisal combines the evidence from a complete history. The presumptive cause of the condition in each case should be established. The history must take into account such things as sensory handicaps, motor disabilities, emotional disturbances, behavior disorders, and environmental deprivation. One must remember that the diagnosis of mental retardation, especially during the developmental period, is prognostic and therefore quite tentative.

Case Material

The following cases illustrate some of the ways in which the public health nurse helps to teach and counsel families with mentally retarded children.*

The public health nurse may follow a retarded child or suspect from time of birth or at any time during his preschool years. In the case of Peter, who is a mongoloid, the public health nurse saw him when he was a few weeks old. He was referred to the services by the Crippled Children's Division because of other anomalies. Regular visits were made by the public health nurse to the home to help the mother with a severe feeding problem. Peter's mother, being an older woman and a careful housekeeper, found the tedious and time-consuming task of feeding him frustrating and nerve racking. She needed a great deal of support, encouragement, and information during the early months. The public

*Case material supplied by Louise W. Sylvester, R. N.

health nurse provided this and was on hand to help her introduce each new food to the child. By actually feeding the child, a new technique was demonstrated, giving the parents the feeling that tangible aid was given. It also gave the parents an opportunity to relax and to express their own feelings of concern. This was necessary because while Peter's condition was explained to the family by the physician when the child was a few months old, like many parents, the diagnosis of retardation was not easy to accept and they did their share of shopping around in hopes of a more favorable one.

In the meantime, the public health nurse continued in the home weekly helping the mother and child with each new step, teaching the child to hold a cracker, a cup, a spoon, and finally self-feeding. When Peter was ready for self-dressing, devices such as a large button and buttonhole on cloth and a toy lacing shoe were used. These proved helpful in increasing the child's skill as well as proving many happy hours of play.

Counseling Aids Parents

Peter is a lovable child; his parents and older brothers and sisters lavished love and affection upon him to the extent of spoiling him. It was obvious that the whole family needed help in the area of discipline which is essential if the child is to develop into a well-adjusted and fairly independent individual. The parents through counseling were helped in working out a consistent method of disciplining him.

By the time Peter was four years old, the parents' chief concern was that he did not speak. They had consistently rejected any suggestions of a psychological examination being done but were enthusiastic about a speech evaluation. Arrangements were made with the speech therapist to see the child and she explained to the family that a psychological examination was essential in order to determine what could be expected of the child. The parents were now ready to accept this procedure and tests were done. By this time they were willing also to accept the diagnosis of severe retardation and were determined to care for him in the home. This was encouraged and in order to help them more, the speech therapist on occasion would accompany the public health nurse on her visits to teach ways and means of stimulating the child's speech.

Peter eventually became an overactive and fearless child, requiring his mother's full-time attention to keep him from danger. As he was eligible for the Day Care Center Program, the public health nurse encouraged the mother to consider the possibilities of daytime care to relieve her of the constant supervision and to give her more time to devote to her family and outside activities. It was also pointed out that the child would derive benefit from socialization, organized play, training in daily living, and discipline. The parents were given literature, and other information and were invited to visit a Day Care Center. They were, however, not pushed into making a decision.

One day the mother called stating that they had decided to enroll Peter in the Day Care Program. She asked that the public health nurse make the necessary referral. This was done and within a few weeks Peter was accepted. Now he is called for each morning and returned to his home the same afternoon in a bus under the supervision of a trained attendant. Peter is happy about his ride, his school, and his new playmates. His parents and siblings are enthusiastic about this arrangement, too.

A Good Working Relationship

Both mother and father are active in the Parent Group and are interested in learning more about their child's condition and in making life better and happier for all such children. They realize that their child will always need some type of supervision and are making plans for his future. The public health nurse will continue her work and interest in the child and his family and offer help, encouragement, and support whenever it is needed and desired.

Since each child is an individual and each family a unit, no one special program or plan can be expected to meet the needs or provide a satisfactory solution for all mentally retarded children and their parents. What worked well for Peter and his family would not have been feasible in the case of little Tommy and his parents. We came to know this child and his family through a routine home visit to a newborn child. In the beginning there seemed little that the nurse could do or little that the family needed. Tommy's parents were young and intelligent. They had established a comfortable and happy home and their four other children were well adjusted.

Programs Geared To Each Case

From the beginning, Tommy had persistent vomiting and was under the care of a pediatrician. With the doctor's permission the public health nurse continued to make occasional visits into the home often enough to keep abreast of any new developments. As Tommy's parents had had experience with four normal children, they knew that this child was not progressing as he should. Now they began their endless search from one doctor to another, from one hospital to the next, always hoping for a cure or improvement in the child's condition, always disbelieving that this could have happened to them.

Tommy at twelve months of age was a small pale child content just to lie in his crib. He made no effort to hold his own bottle and was having frequent seizures. His mother never left his side and gave him around the clock care. The strain was taking its toll on her physical health and the emotional and social health of the entire family. Family life began to disintegrate and there was marital discord. The mother talked to the public health nurse freely about what was happening to her once happy and well adjusted life. She talked about the frustrations and confusion resulting from seeking advice from so many different people and agencies, each with their own opinions and feelings. The public health nurse, being the one constant person to work with the family, was instrumental in bringing about a conference of the various members of the team presently involved. As a result of the team conference, which included the family physician, priest, pediatrician, psychologist, and social worker, pertinent information was obtained. Reports and recommendations were requested from other doctors and hospitals having previously seen the child. With this information it was more clearly understood what the mother had been told and what she had not been told. It was the pediatrician who was selected to tell the parents how severely retarded the child was and what little could be expected of him. Because of the mother's poor physical and emotional state, institutional care was recommended for the child but that decision was left entirely to the parents. Parents of mentally retarded cridren almost always feel guilty about making this decision and need the support of all the team members. They feel guilty about giving up their own child and yet if the child remains at home they are apprehensive about his effect on the other children.

Parents Face Difficult Decision

Tommy's parents, with a great deal of mental and emotional anguish, decided upon the residential type of care. They asked that arrangements for admission to the Hospital for the Mentally Retarded be made as soon as possible. After admission to the hospital, the public health nurse continued in the home weekly, acting as liaison between family and hospital until both the parents and the child adjusted to the new situation. Tommy's parents now believe that they have done the best for all members of the family. The physical and emotional health of the home has greatly improved.

While some children profit from partial or complete care outside the home, others with the parents being helped through counseling and guidance. Such a program was decided on for a little fellow we shall call Dickie.

Dickie was nearly six years old when he came to our attention. His parents were young and financially insecure when he was can be managed well in their own homes born. The mother returned to work when the infant was a few weeks old, leaving him in the care of friends and neighbors. During these first years of life, she saw him only during the sleeping hours and with her limited knowledge of normal child development, she was not aware of how slowly Dickie was progressing.

After the birth of a second child, the mother gave up her job and assumed the full care of both children. She then started making comparisons in their developmental and behaviour patterns; but it was not until Dickie was nearly four years old that the parents consulted a psychologist upon the advice of the family physician. Evidently the diagnosis of mental retardation was not acceptable to them and they convinced themselves that the doctors were wrong and that the child would outgrow his problems and difficulties. They also felt that financially they could not afford professional guidance and decided to "let nature take its course."

After two trying years, the parents began to face the fact that they did need help with the child's management and training. Dickie was also approaching school age and they were concerned about his education.

The mother first learned of our services through a neighbor who was familiar with our State Board of Health program for the mentally retarded. By now the parents were desperate and open to any suggestion. The child was socially unacceptable to them and to others. He was a noisy and destructive child, although at times he was completely withdrawn and out of reach. His parents felt inadequate in dealing with him in every respect. They had had no success with toilet training, dressing, or eating habits. The mother was extremely nervous and confused. She did not understand her feelings toward herself and the child. She readily agreed to psychological examination preliminary to further planning for him. Examination revealed an emotionally disturbed child with effective intelligence at the retarded level. He also had severe language retardation. The psychologist recommended that psychotherapy be instituted as soon as possible and that the mother be given guidance in handling the child, in training and in stimulating him to respond constructively to social situations. The diagnosis and recommendations were discussed and interpreted to the family. When they understood Dickie's need for psychotherapy, they agreed to clinic referral and the necessary arrangements were made. The public health nurse continues to work closely with the psychologist and to make weekly visits into the home. Her acceptance of the child as he is has helped his parents to accept rather than reject him, as they were unconsciously doing. Dickie responds favorably to this new sense of worth and his father now actually enjoys doing simple things with him.

During the public health nurse's weekly visits, Dickie's mother is helped with planning daily routines, simple child training methods, and discipline. The visits are unhurried and the mother is given time to discuss her problems, successes and failures with the child in an effort to help her understand him better. We are trying to make her feel that she is not alone in helping her child reach his full potentials. A part of each visit is set aside for actual play with the child. These activities may consist of reading, coloring, block building, or music. Within a few months the child's interest span has increased; he has become more sociable and less self-centered. His vocabulary has increased and he plays better with other children. It is hoped that with continued therapy and counseling at the clinic, together with the weekly visits of the public health nurse, Dickie will be able to enter a special class by this fall.

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A PLEA FOR INTENSIFIED INVESTIGATION OF VENEREAL INFECTIONS

● **The physician who treats patients for venereal disease must assume full responsibility for optimum management of the situation. The health department offers trained investigators to help the busy physician fulfill this responsibility more easily without violating the strict confidentiality of the patient-doctor relationship.**

WINDER L. PORTER, M.D.*

The advent of the antibiotic era has made the treatment of venereal diseases more simple, more economical and more effective. Consquently more physicians undertake to manage these diseases as part of their general practice This has made acceptable treatment accessible to more persons but carries with it increased responsibilities. The physician who undertakes such management needs to be thoroughly acquainted with the differential diagnosis and with the natural history of these infections. It is not enough to treat the plusses, but one must have some conception of the stage of syphilis at the time of treatment so as to know what to expect in response to treatment. With infectious syphilis and gonorrhoea, the responsibility does not cease with the termination of treatment but the patient should be followed at appropriate intervals and long enough to be sure the desired response has been attained.

There is a responsibility to determine the source of the infection, and also to protect others who may unwittingly have been infected by the present patient. With late syphilis, this applies to examination of the marital partner and of the offspring of infected mothers. With possible congenital infection, parents and siblings warrant investigation. With recently acquired infection, the investigation must involve not only the marital partner but also all with whom the patient may have cohabited within the period of infectiousness. With gonorrhoea so difficult to diagnose in the female, it is good practice to treat on an epidemiologic basis all those who have been named as contacts of males with gonorrhoea. It is also accepted practice to treat prophylactically all persons known to have been sexually exposed to infectious syphilis.

All Contacts Must Be Obtained

Many a physician is quite convinced that he is capable of conducting a satisfactory venereal disease interview to elicit contacts of infected cases. He is usually quite pleased when he obtains one or two contacts and

*Director, Division of Venereal Disease Control.

feels entirely satisfied if the man brings his wife in for examination even if the paramour is left free to infect someone else. Few can spare the time necessary to elicit all contacts which may be obtained, and most are quite unprepared to accept the role of homosexual activity in this regard. Perhaps suspicion is aroused when the patient has effeminate actions and characteristics, but the possibility is not even considered when the patient is a burly truck driver, particularly if he is married and has a child or two, and certainly not when the patient is a pillar in the business or professional world. Many urban areas report a disproportionate percentage of new syphilis cases in males because of homosexual spread. A peculiar feature of these homosexual exposures is the wide disparity in status of the individuals involved. The male is apt to indulge his promiscuous heterosexual activities with women in his own social sphere, if not his secretary or waitress, while the homosexual seems to have utter disregard for the age, race, culture, social status or economic position of his contacts. Some are discreet enough to seek their escapades in places remote from their own homes and flock to urban areas where their perversions are more readily concealed.

Long, Tedious Sleuthing Required

Specialized training is necessary to elicit these contacts and long tedious sleuthing is required to locate them and get them to examination and appropriate treatment. Nationwide, some fifteen per cent of venereal disease contacts named live outside of the state where reported. With a small state like Delaware, a much larger percentage will be non-resident and therefore require organized cooperation between workers of several states to secure for them necessary examination and treatment. Your health department offers the services of trained interviewers and investigators to facilitate this epidemiologic effort. The investigator stands ready to assist the physician in applying necessary diagnostic modalities, with interviewing the patient for contacts and for interpretation of his infection to him, with locating and returning delinquent patients for further study, and with procurement of drugs needed for the medically indigent VD patient.

Some physicians hesitate to call upon a trained interviewer to assist with VD problems for fear there will be a violation of the sacred patient-doctor relationship. Persons assigned this responsibility are thoroughly indoctrinated with the principles of absolute confidence, avoidance of offense and of strict regard for the social and marital complications which may develop. They are chosen because of tact, personality, resourcefulness, intelligence and demonstrated sense of responsibility, and these basic qualifications are supplemented by continuous training and development of newer techniques. Actually most patients appreciate that this is an area which puts too much demand upon the doctor's valuable time and are readily convinced that he has their best interests at heart when he enlists the aid of a trained investigator. Most also accept that their personal confidence will be respected and that their role of informer will not unwittingly be revealed.

BFP Serologic Test

The problem of the Biologic False Positive serologic test is real, extensive and necessarily cause for great concern. With reduction of the per capita incidence of syphilis, the percentage of reactive serologic tests which are BFP naturally increases. The over-all incidence in the entire population can only be guessed, but it is still certain that in lower socio-economic groups syphilis is by far the most common cause of reactive serologic tests. Physicians who draw their clientele principally from other brackets are prone to disparage the significance of reactive tests in their patients, particularly when in low titer. The admonition here is to give them full credence particularly when the result is sustained on repeated testing and there is no obvious explanation for the BFP. Before shifting to another laboratory, repeat the test in the same laboratory to ascertain if the findings are confirmed and sustained. Re-

view the history for previous S.T.S. results and for indications of possible lesions or for serial injections at any time. Examine the spinal fluid and look for physical signs. Many physicians escape the realization that most of the syphilis we see today is in the latent stage and therefore is not detectable by the most exhaustive examination. But enough do have sufficient structural atteration to make the search worthwhile. Many infections in young adults will be congenital and there will be corroboratory evidence in the form of stigmata or of infection in other members of the family. Examine these relatives. Explore the role of previous antibiotic therapy. Employ the RPCF test as a further screening device bearing in mind that while a reactive result is considered quite significant, a negative result does not exclude either recent infection, or old infection modified by treatment long ago. With the RPCF negative, the liklihood that the patient needs treatment is greatly reduced. The Delaware State Board of Health Laboratory will perform the RPCF test in cases where the history and previous test results are reported on an appropriate form. As a final screening procedure, TPI testing can be secured but only in cases which are thoroughly documented and have been completely studied via routine tests, spinal fluid examination and RPCF testing.

Syphilis Information Often Buried

Serologic testing is often a part of routine hospital admission procedure. It is sometimes difficult to see why the practice is continued as so little attention is paid the result. The discharge summary often devotes considerable space to evaluation of abnormal serum proteins, or cholesterol, or other disturbances in blood chemistry while not a word is devoted to syphilis as a diagnostic consideration. Indeed the patient may die and there be an extensive exposition of the autopsy findings with syphilis again remaining unmentioned. The significance of the reactive S.T.S. will often come to light if one just takes the time to review the patient and his history. Further screening as outlined in the preceding paragraph is just as important as many of the detailed studies pursued in the effort to explain other abnormal chemical determinations. The modern practitioner of medicine has failed to serve his patient adequately when he does not give syphilis the respect and consideration it still deserves, particularly since such handsome rewards may follow relatively simple treatment.

SUMMARY

1. Most venereal infections can readily be handled by the general practitioner.
2. In treating such cases, the practitioner must assume responsibility not only for adequate treatment and follow-up, but also for extension of investigation to other contacts who may be infected.
3. Prophylactic treatment of females exposed to gonorrhoea and of all persons exposed to infecious syphilis, is good medical practice.
4. The health department desires to cooperate with the physician so that his services become more effective.
5. Trained investigators are available to assist the physician in his VD control efforts.
6. Possible BFP reaction presents a problem which often can be resolved if study of the patient is pursued systematically.
7. Reactive tests on routine hospital admissions and similar studies warrant respect and consideration as well as diligent attempts to document the true status of the patient.

MAKE A NOTE ON YOUR CALENDAR OF THIS IMPORTANT DATE

NOVEMBER 8th, 1960

October 15th is the last day for registration in Delaware

● **The author who was contacted in March, 1959 by a representative of the Avon Club** in Felton, Delaware, and asked to speak at their next meeting on the subject of Health and Sanitation, presents this survey of the situation.**

A SANITARY SURVEY OF FELTON

MAYNARD H. MIRES, M.D.*

Felton, Delaware is located twelve miles due south of Dover on the dual highway, and has a population of 450 (according to the latest estimates). It would be a typical lower Delaware farming community, except for the added advantage of having a large poultry processing plant owned by Swift & Co., which employs about 130 men and women. For this and other reasons, Felton is growing far beyond its conventional limits established in 1883. The pattern of suburban growth thus emerges; the tendency is for the younger couples and the newcomers to build their homes outside the town limits, leaving the "old-timers" in their large mid-Victorian homes nearer the center of town. In a situation like this, there is always the question of who is better off: the person receiving all the town services or the person who pays no town taxes?

Now the resident of Felton cannot complain of high taxes, but he can and does complain of the lack of a public sewerage system. The Avon Club members had this in mind when they invited someone from the State Board of Health to speak. They listened patiently that day in April while a sanitarian and I discussed the aspects of environmental sanitation and related a long list of complaints we had received in the past concerning inadequate individual sewage disposal systems in their town. We told them how in many cases the building lots in the older part of Felton were too small to accommodate systems, the ground water table was too high for the digging of seepage pits and there was always the problem of what to do with laundry waste.

A round of spirited and searching questions followed at which time we discovered that these ladies had much more than just a superficial interest in the subject. Thinking to stimulate further activity, we left them a copy (just recently issued) of a National Health Council publication, a guide for the evaluation of one's community health services.

The month of June brought with it a fresh request, this time for a complete sanitary survey of the town of Felton and adjacent areas. Now, sanitary surveys have been done in many places over the past 110 years (since Shattuck's "Report of the Sanitary Commission of Massachusetts")

*Deputy State Health Officer, Kent County, Delaware.

**The Avon Club is similar to women's organizations in other communities which are all united in one large "National Federation of Women's Clubs." Its members who are drawn from all walks of life find an outlet for their creative ideas.

Address: .....
Occupant's Name: .....
Number of occupants ..... Length of occupancy .....
Owner's Name: .....
Address: .....
Lot: Width ..... Depth .....

WATER SUPPLY

Public ..... Individual ..... Is public supply available .....
Well:
Driven ..... Drilled ..... Depth .....
Distance from: tile drains or sewers ..... ft. Septic tank ..... ft.
tile field ..... ft. seepage pit ..... cesspool .....ft.
privy ..... ft. other ..... ft.
sanitary defects: .....
Results of analysis: 1 ml ..... 10 ml .....

SEWERAGE

Privy ..... Individual ..... system
Privy: Clean ..... flytight pit .....
surface drainage satisfactory .....
Individual system: grease trap ..... septic tank .....
seepage pit ..... tile field ..... cesspool .....
Dimensions of units .....
Condition: Satisfactory ..... overflowing .....
has overflown ..... frequently .....
infrequently ..... how corrected .....
other difficulties .....

FACILITIES

Garbage grinder ..... automatic washing machine .....
automatic dishwasher .....
Any complaints of insanitary conditions in vicinity .....
if yes, identify .....

TRASH PICK-UP

By homeowner ..... someone else .....

so that we were pleased to accept this rather routine duty. A questionnaire form for this purpose had previously been developed by the Division of Sanitary Engineering, and covered the items listed above.

The Town of Felton originally was laid out within square boundaries so it was easy enough to divide the area to be surveyed into quadrants and number each home thereof. The four inspectors devoted the week of June 8-12 to this project, meeting with a most favorable reception as they went from door-to-door. Publicity for the survey had been handled by the ladies, so everyone was well prepared for our visit. As a sidelight, we might mention here that 10% of the homeowners made some alteration or improvement in their environmental sanitation as a result of this pre-survey publicity.

One hundred ninety-three homes and other types of buildings were visited during

this week, representing more than 95% of the total. One hundred seventy-three of these were found to be on the municipal water supply, and the remaining 20 had a private supply (16 of these had access to the water main but had not taken advantage of it).

Findings

The most important item, sewage disposal, showed that 68 had an outside privy and 15 of these were not acceptable according to State Board of Health standards. One hundred fifty-six had individual sewage disposal systems; 47 of these were unsatisfactory at the time of the survey, and 11 others had had trouble in the past. It is, of course, obvious from simple addition that some houses had both a privy and a sewage disposal (water-carriage) system.

Only 2 houses had garbage grinders. This is not surprising in view of the fact that the great amount of water needed for such an appliance automatically necessitates a 50% addition in one's total seepage area.

Forty-three houses had automatic washing machines; the wash water was then disposed of in the following ways:

A. Three were connected to the sewage disposal system.

B. Sixteen had a separate system.

C. Twenty-five had no system at all, but discharged it into the street or a nearby ditch.

The question on trash pick-up showed that 59 homes had their trash hauled away by a local gentleman who does this regularly for a small fee. Fifty householders hauled their own trash away. The others apparently had no trash!

These findings were presented to the next meeting of the Avon Club, along with the recommendations that a firm of consulting engineers be hired to come to Felton and estimate the cost of a system of collecting sewers and a treatment plant. The ladies agreed, and then countered with a few recommendations of their own:

1. Let's investigate other aspects of health and sanitation in Felton.

2. There should be added to the National Health Council booklet a section on housing. (Felton, as any other community, has some eyesores which ought to be torn down.)

3. Why don't we have a local board of health which would be empowered to deal with more than gross nuisances or in emergency conditions of epidemic disease?

All of the above have been acted upon, except the one calling for consulting engineers. However, when money is found for this project, you may rest assured that it will be done. The mayor and town council, incidentally, have not stood idly by while their womenfolk did all the planning; they, too, are vitally concerned in this future improvement.

The National Health Council has been greatly impressed by activity going on in two American communities as a result of its "Guide:" Gastonia, North Carolina and Felton, Delaware. There is even some talk of a little financial help if these communities take the necessary steps.

SUMMARY

The official health agency in this story had been struggling along with the problem of sewage disposal in a small Delaware town until a group of club women showed them the way. Having been furnished with a copy of the "Guide to Community Health Services" by the county health officer, this study group set about to obtain their objective in three steps:

1. All members of the organization were urged to become familiar with basic sanitary needs and suggested standards of practice to meet these needs.

2. They were urged to measure local sanitary needs and to inventory the adequacy of facilities to meet these.

3. They planned activities and programs designed to bring about the indicated changes.

THE PATIENT, THE PHYSICIAN AND THE CHIROPODIST

● **The chiropodist, working in his office and in the hospital clinic, is an importnt member of the medical team, particularly in the treatment of diabetes.**

V. LEONARD BROWN, D.S.C.*

The patient, who for the first time in his life realizes that he has diabetes will soon learn that two of his best friends in the medical field will be the Physician and the chiropodist. He will find the physician to be understanding, outline the proper diet and prescribe the proper amounts of insulin and/or the new oral tablets. The patient then must be made to realize that the care of his feet is just as important as the following of his diet and the administration of his insulin. He must realize that the foot is a greater distance from his heart than any other part of his body and is the last place for arterial blood to reach. With increased age, it will become the most easily infected part.

Home treatment on corns and callouses with medicated corn pads can be the beginning of infection, ulcers, gangarene and even death for the diabetic. Many people develop the so-called "club nails" or hypertrophied toenails that grow fast and thick. They must be cut with the utmost care as the nail plate curves and the normal epidermis grows up into the thickened nail and is too easily caught in the toenail clippers and a deep cut is easily inflicted.

The average diabetic should follow the normal foot hygiene rules and should visit the chiropodist periodically, the time between visits to be determined by the foot specialist. The chiropodist sees many different people every day and is always alert for diabetes in his patients, whether new ones or old.

In many instances, the chiropodist will notice in one of his regular patients a rapid loss of weight; a complaint of chronic fatigue, cuts or small sinus tracts at the bases of deep corns that are slow to heal, a complaint of numbness in the toes or feet or a flatulance in the tissues around the heel. When these signs appear, he tests the urine for sugar and finding any trace, he immediately sends the patient to a laboratory in a hospital for a blood sugar and if the results are positive, the patient then is sent to his physician.

The scope of the chiropodist's practice is clearly defined in the Chiropody Practice Act of the State of Delaware which is:

*Doctor of Surgical Chiropody.

"The diagnosis and the medical, surgical, mechanical, manipulative and electrical treatment of all ailments of the human foot and leg, excepting amputation of the foot or leg or the administration of an anesthetic other than local."

The foot specialist has no desire to practice beyond his limitations and refers any case that is systemic in origin to the proper practitioners.

The chiropodists of the city of Wilmington are staffed on three of the four city hopsitals and conduct clinics in these hospitals at regularly scheduled times.

This gives the hospitals another department to better serve the community and add to its stature. The chiropodist in these clinics sees many patients and instructs over and over again the patient with diabetes and/or peripheral vascular disease and the importance of regular foot care.

Many medical directors of large hospitals have noted a drop of fifty per cent in amputations of the lower extremities after chiropodist were staffed in the hospitals and would examine and/or treat all patients in the metabolic department. It is compulsory for all new diabetic patients to see the chiropodist on their first visit whether they do or do not have a foot complaint. Then the foot doctor tells them when to report back to the foot clinic.

More patients with peripheral vascular disease or diabetes develop infection, ulcers or gangrene from "corn pads" than from any other cause and the hazards of using these products must be repeatedly drummed into the patient's mind. Home treatment with razor blades is a cardinal sin and may be the first incision of many incisions that could terminate in amputation of the extremity.

It is not the treatment of the infection in the diabetic that is paramount; it is the prevention of infection.

Contributors Column

Ralph M. Myerson, M.D., Tufts College '42, has done extensive postgraduate work in neurology, gastrointestinal diseases and endocrinology and has published more than 50 articles dealing with the application of new techniques for diagnostic and therapeutic purposes. Dr. Myerson is also clinical professor of medicine at Woman's Medical College of Pennsylvania.

Dr. Fred A. Stonesifer, University of Pittsburgh and Ph.D., Pennsylvaia State University, has served on the staff of the Bureau of Mental Health, Penna. Department of Welfare and on the staff of the Selinsgrove State School for epileptics and mentally retarded. Dr. Stonesifer is president-elect of the Delaware Psychological Association and a representative for Delaware for the American Association on Mental Deficiency.

Winder L. Porter, M. D. received his degree in Medicine from the University of Pennsylvania where he also earned his M. P. H. He served a rotating internship at the Cleveland City Hospital and a year as resident in Pediatrics at the Provident Hospital in Chicago, Illinois. He joined the staff of the State Board of Health in 1942, working principally with the child health and venereal disease programs. He is certified by the American Board of Preventive Medicine and Public Health, and is a charter fellow of the American College of Preventive Medicine.

Eleanor R. Belfint, R.N., and Louise W. Sylvester, R.N., are both certified in Public Health Nursing by the University of Pennsylvania. Miss Belfint is a graduate of St. Joseph's Hospital School of Nursing, Philadelphia. Miss Sylvester is a graduate of the Delaware Hospital School of Nursing, Wilmington.

Books

Recent Accessions to the Library of the Delaware Academy of Medicine

BACTERIOLOGY and IMMUNOLOGY

Gunsalus, I. C. and Stanier, Roger Y., eds.: The Bacteria, Volume I: Structure, 1960. Academic Press

CARDIOVASCULAR SYSTEM

Warshaw, Leon J. ed.: The Heart in Industry, 1960. Hoeber

DENISTRY

Hirschfeld, Leonard: Minor Tooth Movement in General Practice, 1960 Mosby

Stinaff, Robert K.: Dental Practice Administration, 1960. Mosby

GASTROINTESTINAL SYSTEM

Wells, Charles and Kyle, James: Peptic Ulceration, 1960. Livingstone

HISTORY of MEDICINE

Cunningham, H. H.: Doctors in Gray. The Confederate Medical Service, 2nd ed., 1960. Louisana State University Press

Rogers, Fred B.: Help-Bringers. Versatile Physicians of New Jersey 1960. Vantage Press

MISCELLANEOUS

Spiegelman, Mortimer: Ensuring Medical Care for the Aged, 1960. Irwin

Stanford Research Institute: Chiropractic in California, 1960. Haynes Foundation

MUSCULOSKELATAL SYSTEM

Mennell, John McM: Back Pain, 1960. Little, Brown and Company

NERVOUS SYSTEM

Works of the Institute of Higher Nervous Activity: Pathophysiological Series, 1957. Volume III. Academy of Sciences of the U.S.S.R.

OBSTETRICS and GYNECOLOGY

Smout, C. F. V. and Jacoby, F.: Gynecological and Obstetrical Anatomy and Functional Histology, 3rd ed., 1953. Williams and Wilkins

PEDIATRICS

Rose, Harry M.: Viral Infections of Infancy and Childhood, 1960. Hoeber-Harper

Schaffer, Alexander J.: Diseases of the Newborn, 1960. Saunders

PHARMACOLOGY

Bartter, Frederic C.: The Clinical Use of Aldosterone Antagonists, 1960. Thomas

PHYSIOLOGY

Ruch, Theodore C. and Fulton, John F.: Medical Physiology and Biophysics, 18th ed., 1960. Saunders

PSYCHIATRY

Sher, Elizabeth; Messing, Eleanor; Hirschhorn, Theodoria; Post, Enis; Davis, Annette and Messing, Arthur: The List Method of Psychotherapy, 1960. Philosophical Library

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Hartwell, Shatuck W.: The Mechanisms of Healing in Human Wounds, 1955. Thomas

Thorek, Max: Surgical Errors and Safeguards, 5th ed., 1960. Lippincott

Thorek, Philip: Anatomy in Surgery, 1951. Lippincott

NEW CLINICAL CENTER STUDIES

The National Institutes of Health, Bethesda, Md., enlists the cooperation of physicians in studies of the colon and rectal carcinoma. Encouraging results in the treatment of gastrointestinal carcinoma have been reported using pyrimidine analogues 5-fluorouracil and 5-fluorodeoxyiridine.

The Chemotherapy Service is conducting studies of these agents in order to better define their place in the treatment of gastrointestinal neoplasm. Patients for referral must be in good general condition in order to tolerate adequate doses. Patients can be accepted if they are ambulatory, have normal leukocyte count, renal and hepatic function and if they have metastases in the lung, peripheral lymph nodes or skin.

Write or call: Dr. Clyde O. Bradley, National Cancer Institute, Bethesda, Md., or call: OL 6-4000, Ext. 4251.

President's Page

Samuel C. McCaa

More than a century ago Alexis de Tocqueville reported: "These Americans are the most peculiar people in the world. You'll not believe it when I tell you how they behave. In a local community in their country, a citizen may conceive of some need which is not being met. What does he do? He goes across the street and discusses it with his neighbor. Then what happens? A committee comes into existence, and then the committee begins functioning on behalf of that need, and you won't believe this but it's true. All of this is done without reference to any bureaucrat. All of this is done by the private citizens on their own initiative . . . The health of a democratic society may be measured by the quality of functions performed by private citizens."

This heritage of the American way of life was established by our forefathers. Maintaining such a way of life requires the acceptance of responsibilities of citizenship and hard work by individuals. Osler called "work" the master word in medicine.

The effectiveness of the Medical Society of Delaware is determined by the work of its individual members. Their contributions are organized and multiplied through the device of committees. The responsibilities peculiar to our profession are many, the urge for accomplishment is a mighty incentive. Our Founding Fathers never lost their faith in their ability to meet the obligations of everyday life. We can do no less.

Currently our nation is in a political swivet as to who of our senior citizens need special medical care, how much, how is it to be provided, how is it to be paid for. We need to incite hard thinking on the part of our fellow citizens about the many factors and implications involved in these issues. Their stake in the subject is greater than that of physicians inasmuch as their welfare and lives are involved whenever political machinations lead to deterioration in the medical service available to them.

In most communities health services presently available are not being used maximally. Hospitals, voluntary agencies and physicians offer services which can be increased as the need is identified. Motivation for utilization of such services must accompany their creation and extension.

Those who need any form of medical care should be allowed to participate in planning for such care. This is a basic factor in the phenomenal growth and effectiveness of voluntary prepayment insurance plans. If legislative efforts are directed toward the control of inflation, our senior citizens will plan successfully for themselves. There is not now, and I doubt that there will never be, a satisfactory substitute for personal responsibility in health preservation at any age level of adult life. Have we done our part to encourage the recognition of such facts by our patients, our friends, our neighbors? They are the ones who lose or gain by political manipulations; we who are the technicians in bringing to them the art and science of medicine continue to practice our beloved profession be we slaves in a Pharoah's court, as was Imhotep fifty centuries ago, or members of a society dedicated to free enterprise and the democratic way of life.

Editorials

ALLEN FREAR AND THE GENERAL QUESTION OF GUTS

Guts, says our dictionary, is stamina or grit; see fortitude. Stamina, grit and fortitude seem to characterize Senator J. Allen Frear's recent action in the Senate Finance Committee on the question of medical care for the aged, which, in the opinion of many, will be the major domestic issue in the 1960 elections.

The Republican and Democratic national platforms draw reasonably clear lines of difference on the issue, with Democrats favoring medical benefits for all social security pensioners and the Republicans advocating selective approach with local determination of need and benefit, financially assisted by the federal government.

Headlines to the contrary notwithstanding, organized medicine has a very definite legislative proposal to help the elderly. Title VI of the Ways and Means Committee's bill (H.R. 12580), proposing an expanded program of aid to the states for aged care, has been unequivically endorsed by the AMA. This bill was introduced by Chairman Mills for the predominantly Democratic Committee, which after months of study could not in good conscience recommend the Forand approach embodied now in the Democratic platform. Passed in the House and referred to the Senate Finance Committee, the Mills Bill has been the subject of enormous pressure aimed at liberalizing it to conform to the platform on which Senators Kennedy and Johnson must run.

Now comes the interesting part. Ranking Democrats of the Finance Committee, after Chairman Byrd, are Senators Robert S. Kerr of Oklahoma and J. Allen Frear, Jr., of Delaware. Both men run for re-election this year. After the conventions, in view of the platforms, before the elections, Frear and Kerr wrote a Senate substitute on medical care for the aged, renouncing completely the compulsory, something-for-everyone, social security approach, and adopting the principle of local determination. Despite heavy pressure, with help from Delaware's John J. Williams, ranking Republican, he persuaded the Committee to adopt this version.

Now, all successful office-holders are partisan politicians. Without a party and with a miracle, you can be elected. But even the miracle won't hold up in the daily wear and tear of the legislative process. There is no surplus of successful politicians who will fight for their principles right down to the election, despite the disapproval of the party leaders and the platform. To do this takes conviction and the courage to stand on that conviction. It takes guts. Allen Frear has them.

In Brief

Brother Baboon

The African baboon may hold the key to arteriosclerosis research. For the first time in medical history a creature has been found that has certain similarities to man in the developing of arteriosclerosis. Dr. David H. Baeder, supervisor for research for Ives-Cameron, addressing the Fifth Conference on Bio-Chemical Problems of Lipids at Marseilles, discussed studies being conducted with baboons bred in the U.S.A., and those captured in Kenya, Africa. Unlike many laboratory animals, the baboon possesses some of the same fatty substances as man and develops arteriosclerotic symptoms spontaneously.

New Drug Rulings By FDA

Sweeping changes are going to be required in the labeling of prescription drugs according to the Food and Drug Administration. Stronger regulations will be instituted to insure that physicians receive adequate information about drugs they prescribe and to insure the safety of new drugs. They include: complete information on labels regarding the use, hazards, side effects and precautions in administration of drugs; that new drugs be kept off the market until confirmed by the FDA.

The Ides Of October

For those who must register to vote in the forthcoming presidential election, October 15th has been set as positively the last day in Delaware for eligible residents. Make a note of this on your calendar. Also allot time on the November 8th date in your appointment book for both yourself and your nurse and/or medical assistant to step out and vote.

Medical School Applications Trend

Applications for the year 1959-60 show that for the third consecutive year, the number of individuals applying to U.S. medical schools has decreased, although the over-all number of acceptances increased slightly. It is interesting to note that in the peak period, 1948-50, of an average of 24,338 applications, 7,062 were accepted. During 1959-60, 8,510 applications were accepted of 14,951 made to the schools.

Moonhouse

Algae will supply the necessary oxygen in a 40-ft. insulated ball which has been designed by the Martin Co., under the direction of their chief of space medicine, Dr. James G. Gaume. Divided into four levels, this "closed ecology" will contain hydroponic tanks, animals in cages, a garden—taking up one-third of the space—and living quarters for five astronauts. Even in this lunar house, dividing the chores seems to be a snag, to be ironed out during preliminary tests on earth.

Declining Ratio

In line with the national trend, the number of physicans per capita in Delaware has declined in 1959, according to the Southern Regional Education Board. Delaware has slipped to third place with a total of 540 physicians in this regional survey; Maryland ranks first; Florida second.

Personal Glimpses

Hal W. Geyer, M.D., has been appointed chief, Department of Neuropsychiatry at the Beebe Hospital . . . The American Trudeau Society has changed its name to the American Thoracic Society . . . Members of this national medical group in Delaware are: Drs. Gerald A. Beatty, Lawrence Phillips, Leonard P. Lang, Nathaniel Young, Lewis B. Flinn, E. Willis Hainlen, Wilmington; Felix Mick, M.D., Milford; and Garrit W. H. Schepers, M.D., Newark . . . Nathaniel Young, M.D., succeeded E. Willis Hainlen, M.D., as medical director of Emily P. Bissell Hospital on Dr. Hainlen's retirement, September 15th . . . Gerald A. Beatty, M.D., delivered the address at the 1960 graduation of the Beebe Hospital School of Nursing . . . Daniel J. Preston, M.D., sponsors an annual award for outstanding achievement in surgical nursing to a member of the graduating class, St. Francis Hospital School of Nursing . . .

Growing Interest In Virology

Ruling out suspected cases, thereby giving mental relief to patients and their families as well as avoiding epidemic alarms, has been one of the roles played by Delaware's Virus Laboratory during its first year. Hepatitis research has been proposed as its next project. Eugene R. McNinch, M.D., president of the State Board of Health, congratulated the organization on its activities. Wilmington's health commissioner, James C. Strong, M.D., presented a check to George J. Boines, M.D., president of the Virus Laboratory, to cover the cost of future virus tests for the City Department of Health.

Expansion For Beebe Hospital

Beebe Hospital student nurses are occupying the new $260,000 structure which has been named the Jean Ellen McConnell Nurses Home in recognition of the services rendered by Mrs. McConnell, a member of the Board of Directors.

James Beebe, Sr., M.D., president of the Board, received a letter from the Joint Commission on Accreditation of Hospitals stating that the Beebe Hospital has again been accredited and commended for "maintaining standards deserving of accredited station and for constant effort to improve the quality of patient care."

New Appointment

Charles K. Bush, Jr., M.D., chief inspector for the American Psychiatric Association's Central Inspection Board, has been named to the new position of Deputy Superintendent of Delaware's mental health program. In his new post, Dr. Bush will serve as assistant to Dr. Tarumianz in the administration of three institutions in two mental programs. He will take up his new duties in December.

Anti-Coagulant Therapy

Because the number of patients using anti-coagulants in long-term admininstration has been increasing rapidly, Endo Laboratories has just released a patient-aid booklet for physicians who instruct patients in this therapy, and an "emergency" identification card for the patient to carry as a safe-guard. For copies of this free booklet and card write to: Endo Laboratories, Richmond Hill 18, N.Y.

Vaccinia Immune Globulin (V.I.G.)

This hyper-immune gamma-globulin, prepared from blood provided by the Armed Forces from recently vaccinated service men, contains a high titer of anti-bodies effective in arresting abnormal infection with vaccinia virus, the agent used in vaccination to produce immunity to the related but dangerous virus of smallpox. A program for the preparation and distribution of V.I.G., sufficient to meet the needs of the country, has been established by the American National Red Cross in cooperation with the Armed Forces of the United States as another regular service of the Red Cross blood program. Physicians requiring V.I.G. should telephone the nearest consultant, whose name, address and telephone number may be obtained from the nearest Red Cross regional blood center. The consultant is equipped to arrange immediate transportation to the attending physician.

Flying Physicians

Delaware doctors are organizing a state chapter of the Flying Physicians Association, which is inaugurating a nation-wide Flying Disaster Program. These flying physicians are banding together to volunteer their services for national emergencies. Organizers for the Delaware chapter are: J. Richard Durham, Jr., M.D., State Chairman; Norman L. Cutler, M.D., Co-chairman; Philip D. Gordy, M.D., Disaster Chairman; Carl I. Glassman, M.D., J. F. Hughes, M.D. and Clarence E. Graybeal, M.D.

For That Efficient "Right Hand"

Medical assistants—the essential right-hand for most practicing physicians—will convene for the fourth annual national convention of the American Association of Medical Assistants in Dallas, Texas, October 14-16. The Leadership Seminar will feature lectures on credit and office management plus a round-table discussion of physician-assistant-patient relationships. (A reminder to physicians: Paying your assistant's way is tax-deductible.)

Psychosomatic Medicine Course

Temple University Medical Center, Department of Psychiatry, offers a 20-week postgraduate course in phychosomatic medicine, beginning October 5, 1960. The course, conducted by specialists from the departments of psychiatry, internal medicine and ob-gyn—with H. K. Fisher, M.D., serving as director—is approved for 80 hours of Category I credit by the American Academy of General Practice.

TV To The Fore

A new method of fluoroscopic examination was introduced recently in New York City by Russell Morgan, M.D., of Johns Hopkins University. By using a television technique, the examining physician can intensify the image on a screen in full view of the patient and other interested people and at the same time substantially reduce the radiation exposure to the patient.

Top Billing

Delaware is one of the 14 states in the U.S.A. in which over 75% of the civilian population is covered by some form of voluntary health insurance protection, according to the Health Insurance Institute. Delaware's figure is 77.1%.

Auxiliary Affairs

"FROM EARLIEST ANTIQUITY" . . .

As a contrast to present day reports of the activities of doctors' wives in county, state, and national auxiliaries, perhaps it is well to consider the discussion of activities of eighteenth century women in general, as published in 1796 by one William Alexander, an English physician.

Dr. Alexander's two-volume treatise appeared under the ambitious title of *"The History of Women from the Earliest Antiquity to the Present Time."* Its value seems to lie in the author's revelation of his own "present time" of 1796 rather than in his recording of "earliest antiquity." He wanders through the latter with an occasional mention of writers to whom he is indebted for information — blithefully dismissing the chore of annotation by having "persuaded" himself that "nothing could be more perplexing to the sex, or to which they would pay less attention, than a long list of authors on the margin."

Dr. Alexander regarded his history of women as the "compilation of a work intended for the amusement as well as instruction of the Fair Sex . . . who now spend many of their idle hours in pouring over novels and romances, which greatly tend to mislead the understanding and corrupt the heart . . ."

Through thirty-one chapters, Dr. Alexander discussed a variety of subjects such as the education of females, their employments and amusements, advantages and disadvantages, character and conduct, delicacy and chastity, dress, courtship, matrimony, widowhood, restrictions and customs. It is in the discussion of "employments and amusements" among the ladies of 1796 that Dr. Alexander departed from unbiased factual statements to include a few personal opinions of both sexes.

He said that "Women exempt for subsistence have a great deal of time upon their hands, which domestic duties are not sufficient to fill up . . . In barbaric countries they were slaves to men, ground corn, worked in the fields . . . In 1796," continued Dr. Alexander, "employment is not the mode of the times. In all the polite countries of Europe, those of rank and file as well as those in decent circumstances, having a great deal of time on their hands, with an irresistible inclination to pleasure in whatever form it offers itself, are more often to be met with at the shrine of amusement than of industry. Show, entertainment, or a crowd, the women are more numerous than the men. Theatricals, balls, assemblies, operas, ridottos, and particularly reviews, seem to be the scenes of delight. Riding, walking, sailing, and in some countries, even skaiting, (sic) and being drawn on the ice on sledges, are female amusements. Besides these, and many others too tedious to mention, the women of fashion, spend a great part of their time in receiving and returning visits and in some of the politer nations, modern visiting is not spending a social hour together; it consists only in her ladyship ordering her coachman to drive to the doors of so many of her acquaintances, and her footman, at each of them, to give a card with her name, while the lady of the house, though in the polite

phrase, not at home, is looking through the window all the time to see what passes; and in some convenient time after, returns the visit, and is sure to be received in the same manner."

"Shopping, as it is called, is another fashionable female amusement in order to which, two, three or sometimes more ladies, accompanied by their gallants set out to make a tour through the most fashionable shops and to look at all the most fashionable goods, without any intention of laying out one single sixpence. After a whole forenoon spent in plaguing mercers and milliners, they return home either thoughtless of their folly, or which, perhaps is worse, exulting at the thoughts of the trouble and disturbance they have given.

"But of all the happy inventions discovered by modern ingenuity for the killing of time, card-playing is justly entitled to pre-eminence. With an immoderate itch for this amusement, which we are at a loss whether to reckon public or private, both sexes and all ranks and degrees of people are deeply infected; particularly indolent clergy, and women, who having little to do, dedicate themselves so assiduously to play, that the habit is in many so strong, as to be foolishly reckoned even necessary to their existence. To cards, when made use of only to unbend the mind fatigued with study, or to pass away an idle hour, we have no objection, nor do we flatter ourselves, that anything we can say on the subject will,

BLUE CROSS — BLUE SHIELD ENROLLMENT

The Delaware Group Hospital Service, Inc., announces that September 15-30, 1960 has been designated as a Statewide enrollment period for all Delawareans. There is a contract available for almost every eligible resident; non-group membership, the "65-Limited" contract; "Extended Benefits" contract and student contracts. This is a good time, too, to make contract changes involving coverage and dependents. There will not be another enrollment period until next year. For the convenience of the public, there will be a special evening telephone service: Telephone OL 5-1561 from 8 A.M. to 9 P.M. on week days.

Blood pressure that goes up with stress often comes down with SERPASIL®

(reserpine CIBA)

One reason that many cases of hypertension respond to Serpasil is that many cases are associated with stress. Stress situations produce stimuli which pass through the sympathetic nerves, constricting blood vessels, and increasing heart rate. Hyperactivity of the sympathetic nervous system may elevate blood pressure; if prolonged, this may produce frank hypertension. By blocking the flow of excessive stimuli to the sympathetic nervous system, Serpasil guards against stress-induced vasoconstriction, brings blood pressure down slowly and gently.

In mild to moderate hypertension, Serpasil is basic therapy, effective alone "...in about 70 per cent of cases..."*

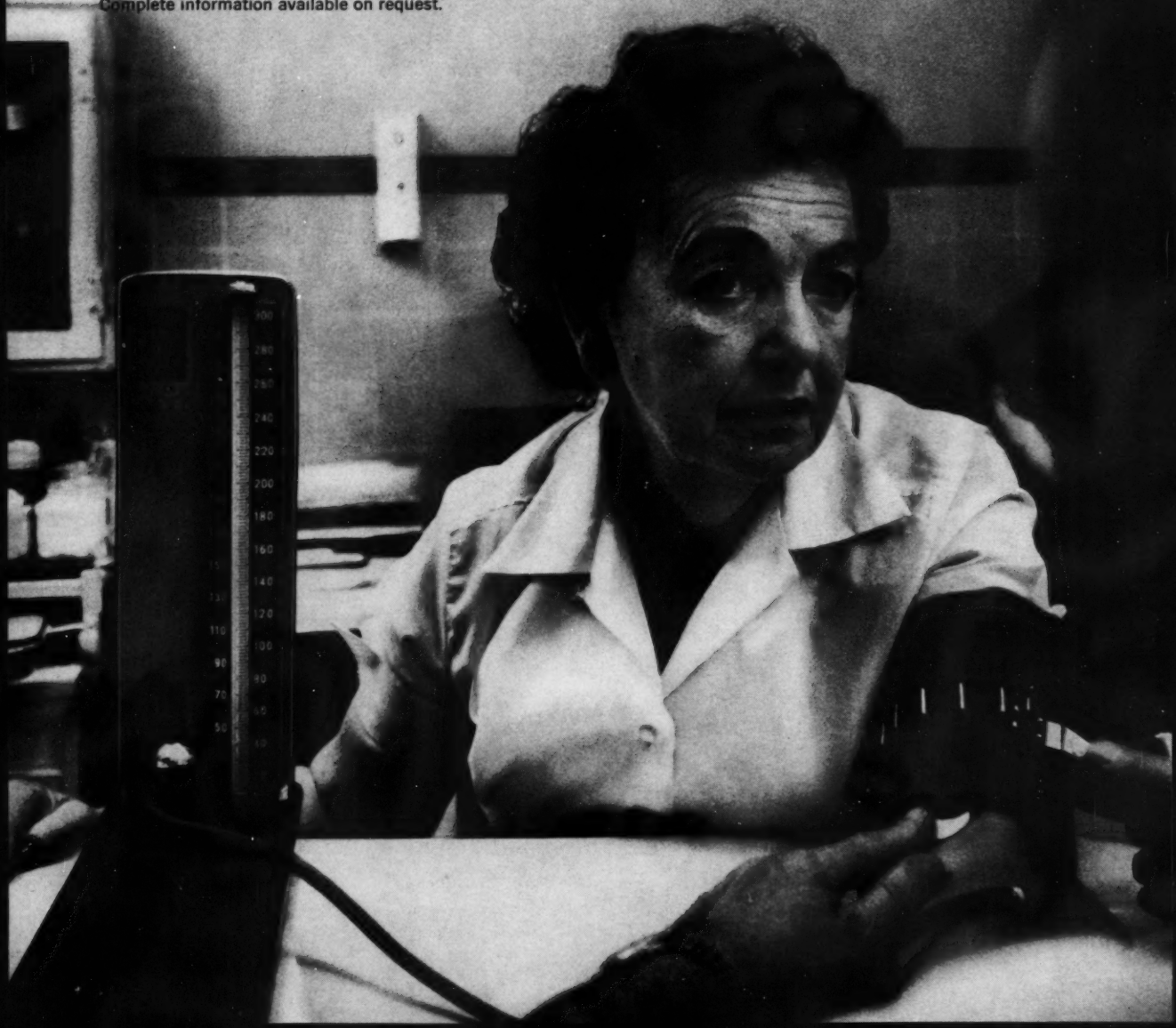
In severe hypertension, Serpasil is valuable as a primer. By adjusting the patient to the physiologic setting of lower pressure, it smooths the way for more potent antihypertensives.

In all grades of hypertension, Serpasil may be used as a background agent. By permitting lower dosage of more potent antihypertensives, Serpasil minimizes the incidence and severity of their side effects.

CIBA
SUMMIT, N. J.

*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955.

Complete information available on request.



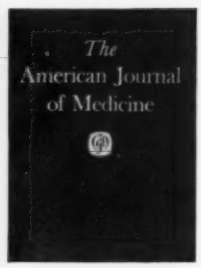
A. H. Robins' new Adabee — for the physician who has weighed the . . .

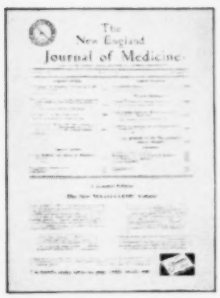
MOUNTING EVIDENCE

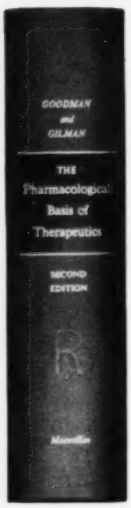
AGAINST

B_{12} AND FOLIC ACID

IN MULTI-VITAMINS







Individually, folic acid and B_{12} fill important clinical roles.[1] But, increasing evidence indicates that multivitamins containing folic acid may obscure the diagnosis of pernicious anemia.[2-7] And vitamin B_{12}, in indiscriminate and unnecessary usage[5-8] is likewise blamed for this diagnostic confusion.[7]

Both folic acid and B_{12} have been omitted from Adabee, in recognition of this growing medical concern. Also excluded are other factors which might interfere with concurrent therapy, such as, hormones, enzymes, amino acids, and yeast derivatives. Adabee supplies massive doses of therapeutically practical vitamins for use in both specific and supportive schedules in illness and stress situations. Thus, new Adabee offers the therapeutic advantage of sustained maximum multivitamin support without the threat of symptom-masking.

references: 1. Wintrobe, M. M., *Clinical Hematology*, 3rd ed., Phila., Lea & Febiger, 1952, p. 398. 2. Goodman, L. S. and Gilman, A., *The Pharmacological Basis of Therapeutics*, 2nd. ed., New York, Macmillan, 1955, p. 1709. 3. New Eng. J.M., Vol. 259, No. 25, Dec. 18, 1958, p. 1231. 4. Frohlich, E. D., New Eng. J.M., 259:1221, 1958. 5. J.A.M.A., 169:41, 1959. 6. J.A.M.A., 173:240, 1960. 7. Goldsmith, G. A., American J. of M., 25:680, 1958. 8. Darby, W. J., American J. of M., 25:726, 1958.

ADABEE®

Each yellow, capsule-shaped tablet contains:

Vitamin A	25,000 USP units
Vitamin D	1,000 USP units
Thiamine mononitrate (B_1)	15 mg.
Riboflavin (B_2)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Nicotinamide (niacinamide)	50 mg.
Calcium pantothenate	10 mg.
Ascorbic acid (vitamin C)	250 mg.

ADABEE® M

Each green, capsule-shaped tablet contains Adabee plus nine essential minerals:

Iron	15.0 mg.	Zinc	1.5 mg.
Iodine	0.15 mg.	Potassium	5.0 mg.
Copper	1.0 mg.	Calcium	103.0 mg.
Manganese	1.0 mg.	Phosphorus	80.0 mg.
Magnesium	6.0 mg.		

indications: As dietary supplements for the deficiency states that accompany pregnancy and lactation, surgery, burns, trauma, alcohol ingestion, hyperthyroidism, infections, cardiac disease, polyuria, anorexia, cirrhosis, arthritis, colitis, diabetes mellitus, and degenerative diseases. Also in restricted diets, particularly peptic ulcer, in geriatrics, and in concurrent administration with diuretics and antibiotics.

dosage: One or more tablets a day, as indicated, preferably with meals.

new! ADABEE®

the multivitamin without B_{12} or folic acid

A. H. ROBINS COMPANY, INC.

Richmond 20, Virginia

Doctors, too, like "Premarin."®

THE doctor's room in the hospital is used for a variety of reasons. Most any morning, you will find the internist talking with the surgeon, the resident discussing a case with the gynecologist, or the pediatrician in for a cigarette. It's sort of a club, this room, and it's a good place to get the low-down on "Premarin" therapy.

If you listen, you'll learn not only that doctors like "Premarin," but *why* they like it.

The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen. Furthermore, if the patient is suffering from headache, insomnia, and arthritic-like symptoms due to estrogen deficiency, "Premarin" takes care of that, too.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

Ayerst Laboratories • New York 16, N. Y. • Montreal, Canada

Ayerst

5842

In over five years

Proven
in more than 750 published clinical studies

Effective
for relief of anxiety and tension

Outstandingly Safe

1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
2. no cumulative effects, thus no need for difficult dosage readjustments
3. does not produce ataxia, change in appetite or libido
4. does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
5. does not impair mental efficiency or normal behavior

Miltown®
meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.
Also as MEPROTABS* — 400 mg. *unmarked*, coated tablets; and as MEPROSPAN® — 400 mg. and 200 mg. *continuous release* capsules.

WALLACE LABORATORIES / *Cranbury, N. J.*

CM-2537

*TRADE-MARK

# of clinical use...

...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

CM-2460

"Gratifying" relief from

for your patients with
'low back syndrome' and
other musculoskeletal disorders

POTENT muscle relaxation
EFFECTIVE pain relief
SAFE for prolonged use

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study*

(as reported in J.A.M.A., April 30, 1960)

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

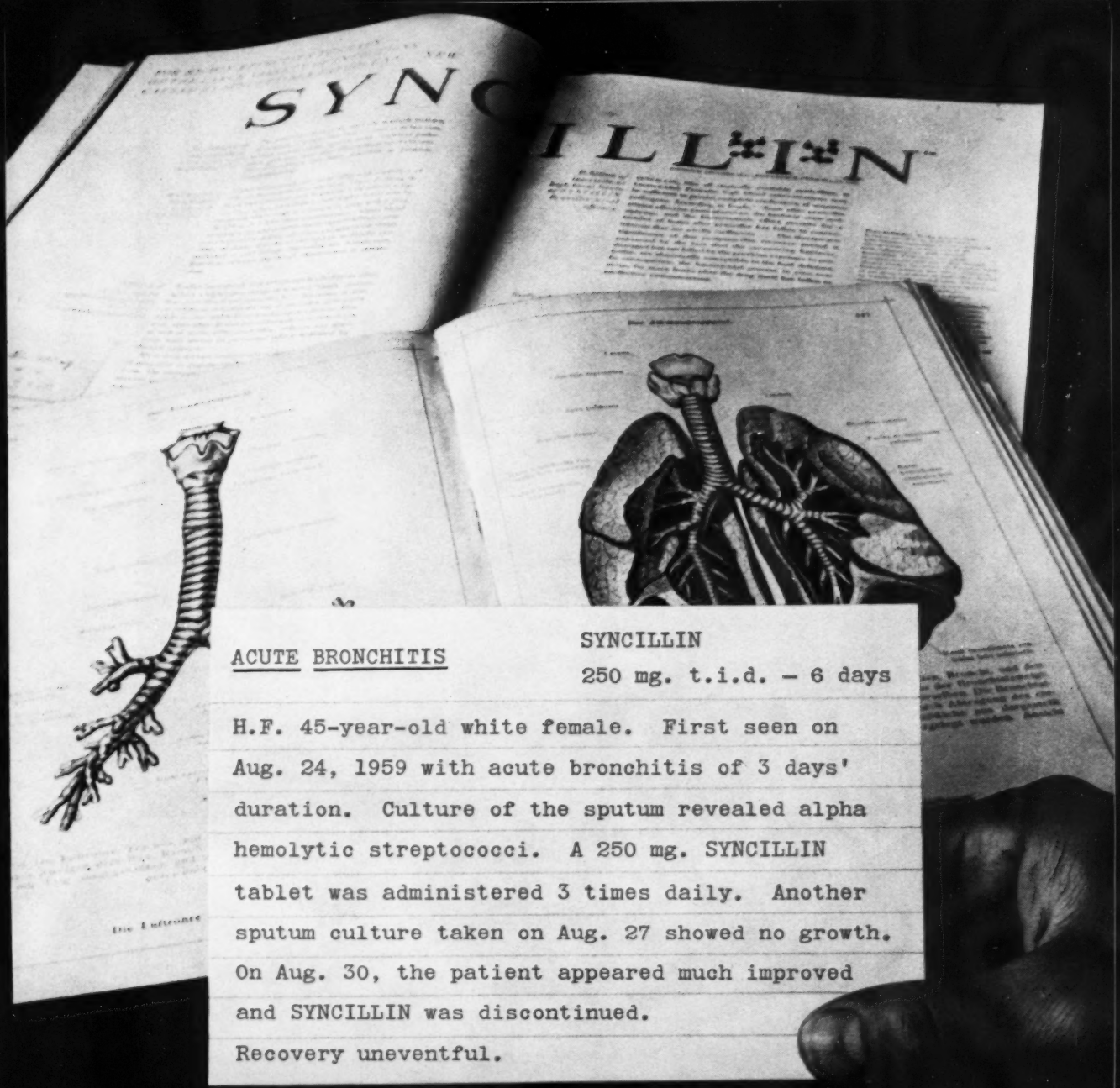
SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

SOMA®

(CARISOPRODOL, WALLACE)

WALLACE LABORATORIES, CRANBURY, NEW JERSEY



Actual case summary from the files of Bristol Laboratories' Medical Department

THE ORIGINAL potassium phenethicillin

SYNCILLIN®

(Potassium Penicillin-152)

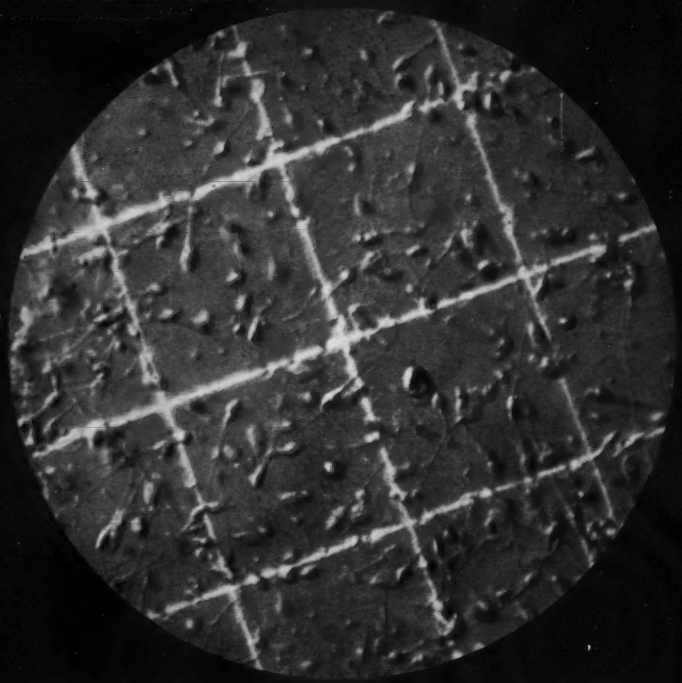
A dosage form to meet the individual requirements of patients of all ages in home, office, clinic, and hospital:

Syncillin Tablets – 250 mg. (400,000 units)... Syncillin Tablets – 125 mg. (200,000 units)
Syncillin for Oral Solution – 60 ml. bottles – when reconstituted, 125 mg. (200,000 units) per 5 ml.
Syncillin Pediatric Drops – 1.5 Gm. bottles. Calibrated dropper delivers 125 mg. (200,000 units)

Complete information on indications, dosage and precautions is included in the circular accompanying each package.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK

IN CONTRACEPTION...



WHY IS DIFFUSION IMPORTANT?

Because the active ingredients of a spermicidal preparation must diffuse rapidly into the seminal clot and throughout the vaginal canal to be clinically effective. Lanesta Gel offers this *dual* protection. Its four spermicidal agents quickly invade the clot to stop the main body of sperm. It spreads evenly and quickly throughout the vaginal canal—seeks out every wrinkle and fold that may offer concealment to sperm. With this rapid diffusion, your patient receives full benefit of the swift spermicidal action of Lanesta Gel — in minutes — a decisive measure in conception control.

In Lanesta Gel *7-chloro-4-indanol,* a new, effective, nonirritating, nonallergenic spermicide, produces immediate immobilization of spermatozoa in dilution of up to 1:4,000. The addition of 10 per cent NaCl in ionic form greatly accelerates spermicidal action. Ricinoleic acid facilitates rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

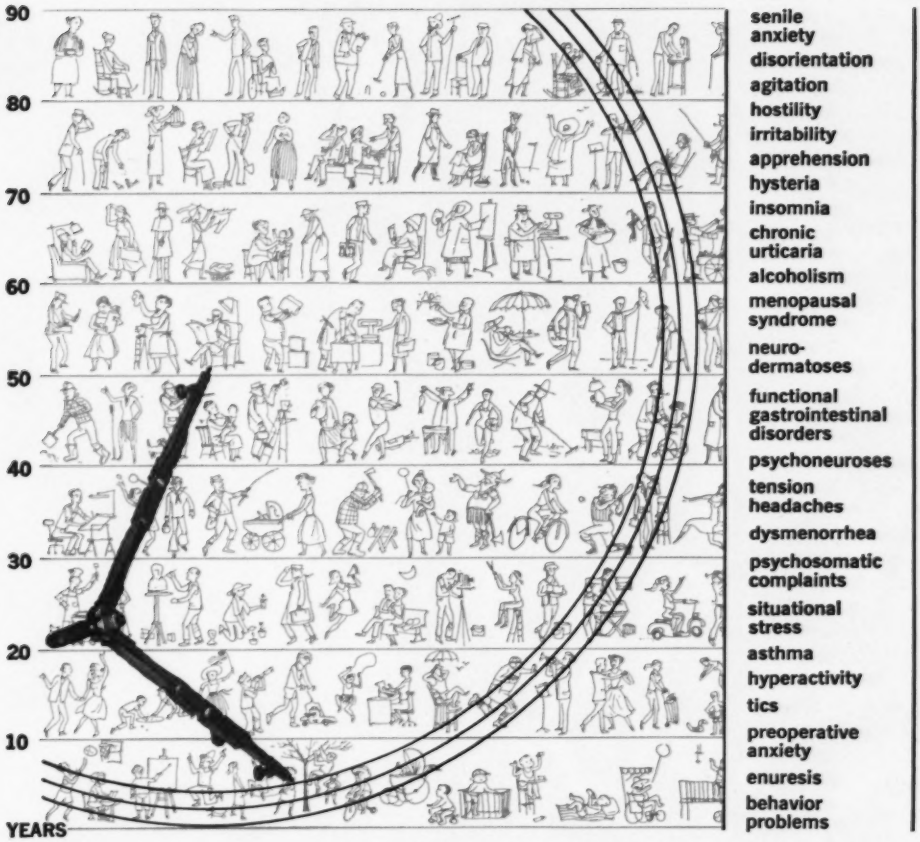
Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action — plus essential diffusion and retention of the spermicidal agents in a position where they can act upon the spermatozoa.

new Lanesta® Gel

Supplied: Lanesta Exquiset® . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

A product of Lanteen® research.

Manufactured by Esta Medical Laboratories, Inc., Alliance, Ohio. Distributed by GEORGE A. BREON & CO., New York 18, N. Y.



ATARAX ENCOMPASSES MORE PATIENT NEEDS...LETS YOU CHART A SAFER, MORE EFFECTIVE COURSE TO TRANQUILITY

ATARAX has a wide range of flexibility . . . from mild adult tensions and anxieties to full-blown alcoholic episodes . . . from the behavior disorders of childhood to the emotional problems of old age. Why? Because it gives you maximum adaptability of dosage . . . works quickly and predictably . . . is unsurpassed in safety.

ATARAX offers extra pharmacologic actions especially useful in certain troublesome conditions. It is antihistaminic and mildly antiarrhythmic, does not stimulate gastric secretions. Hence it is well suited to the needs of your allergic, cardiac and ulcer patients.

Have you discovered all the benefits of ATARAX?

Dosage: Adults, one 25 mg. tablet, or one tbsp. Syrup q.i.d. Children, 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d.

Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules. Prescription only.

Complete bibliography available on request.

ATARAX®

(BRAND OF HYDROXYZINE)

PASSPORT TO TRANQUILITY

Rx only

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

VITERRA® for vitamin-mineral supplementation
• capsules • tastitabs®
• therapeutic capsules

What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest — considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit, you'll be helping patients to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus — watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

now–for more comprehensive control of

'pain & spasm'

INDICATIONS

HEAD: temporomandibular muscle spasm • NECK: acute torticollis, osteoarthritis of cervical spine with spasm of cervical muscles, whiplash injury • TRUNK AND CHEST: costochondritis, intercostal myositis, xiphodynia • BACK: acute and chronic lumbar strains and sprains, acute low back pain (unspecified), acute lumbar arthritis and traumatic injury, compression fracture, herniated intervertebral disc, post-disc syndrome, strained muscle(s) • EXTREMITIES: acute hip injury with muscle spasm, ankle sprain, arthritis (as of foot or knee), blow to shin followed by muscle spasm, bursitis, spasm or strain of muscle or muscle group, old fracture with recurrent spasm, Pellegrini-Stieda disease, tenosynovitis with associated pain and spasm.

-pain due to
or associated with
-spasm of skeletal muscle

a new muscle relaxant-analgesic

Robaxisal®

ROBAXIN® WITH ASPIRIN

Many conditions, painful in themselves, often give rise to spasm of skeletal muscles. ROBAXISAL, the new dual-acting muscle relaxant-analgesic, treats both the pain and the spasm with marked success: In clinical studies on 311 patients, 12 investigators[1] reported satisfactory results in 86.5%. Each ROBAXISAL Tablet contains:

- A relaxant component — Robaxin® — widely recognized for its prompt, long-lasting relief of painful skeletal muscle spasm, with unusual freedom from undesired side effects . . . . . 400 mg.

®Methocarbamol Robins. U.S. Pat. No. 2770649.

- An analgesic component—aspirin—whose pain-relieving effect is markedly enhanced by Robaxin, and which has added value as an anti-inflammatory and anti-rheumatic agent . . . (5 gr.) 325 mg.

INDICATIONS: ROBAXISAL is indicated when analgesic as well as relaxant action is desired in the treatment of skeletal muscle spasm and severe concurrent pain. Typical conditions are disorders of the back, whiplash and other traumatic injuries, myositis, and pain and spasm associated with arthritis.

SUPPLY: ROBAXISAL Tablets (pink-and-white, laminated) in bottles of 100 and 500.

Also available: ROBAXIN Injectable, 1.0 Gm. in 10-cc. ampul. ROBAXIN Tablets, 0.5 Gm. (white, scored) in bottles of 50 and 500.

[1]Clinical reports in files of A. H. Robins Co., Inc., from: J. Allen, Madison, Wisc., B. Billow, New York, N. Y., B. Decker, Richmond, Va., C. Freeman, Jr., Augusta, Ga., R. B. Gordon, New York, N. Y., J. E. Holmblad, Schenectady, N. Y., L. Levy, New York, N. Y., N. Loftus, Chicago Heights, Ill., H. Nuchman, Richmond, Va., A. Poindexter, Los Angeles, Cal., E. Rogers, Brooklyn, N. Y., K. H. Strong, Fairfield, Ia.

Additional information available upon request.

Robins

A. H. ROBINS CO., INC., Richmond 20, Virginia

Making today's medicines with integrity . . . seeking tomorrow's with persistence

"Sometimes, when I have a running nose, I'd like to clear it with **TRIAMINIC®**— just to check out that systemic absorption business.

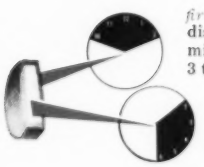
Reaches all nasal and paranasal membranes, huh?"

...and for humans with RUNNING NOSES...

You can't reach the entire nasal and paranasal mucosa by putting medication in a man's nostrils – any more than you could by trying to pour it down an elephant's trunk. **TRIAMINIC**, by contrast, reaches *all* respiratory membranes *systemically* to provide more effective, longer-lasting relief. And **TRIAMINIC** avoids topical medication hazards such as ciliary inhibition, rebound congestion, and "nose drop addiction."

Indications: nasal and paranasal congestion, sinusitis, postnasal drip, upper respiratory allergy.

Relief is prompt and prolonged because of this special timed-release action:



first – the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then – the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl.....50 mg.
Pheniramine maleate.....25 mg.
Pyrilamine maleate.....25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides:

½ the formulation of the Triaminic Tablet.

Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides:

¼ the formulation of the Triaminic Tablet.

Dosage (to be administered every 3 or 4 hours):
Adults – 1 or 2 tsp.; *Children 6 to 12* – 1 tsp.;
Children 1 to 6 – ½ tsp.; *Children under 1* – ¼ tsp.

TRIAMINIC®

timed-release tablets, juvelets, and syrup

STOP *running noses* *and open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

taken at bedtime

BONADOXIN®

STOPS MORNING SICKNESS IN 94%

OFTEN WITH JUST ONE TABLET DAILY

by treating the symptom—nausea and vomiting—as well as a possible specific cause—pyridoxine deficiency

each tiny Bonadoxin tablet contains:
Meclizine HCl (25 mg.) for antinauseant action
Pyridoxine HCl (50 mg.) for metabolic replacement.

usual dose: One tablet at bedtime; severe cases may require another tablet on arising.

supply: Bottles of 25 and 100 tablets. Bonadoxin also effectively relieves nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, and motion sickness. Also useful in postoperative nausea and vomiting.

Bibliography on request.

For infant colic, try Bonadoxin Drops. Each cc. contains: Meclizine 8.33 mg./ Pyridoxine 16.67 mg.

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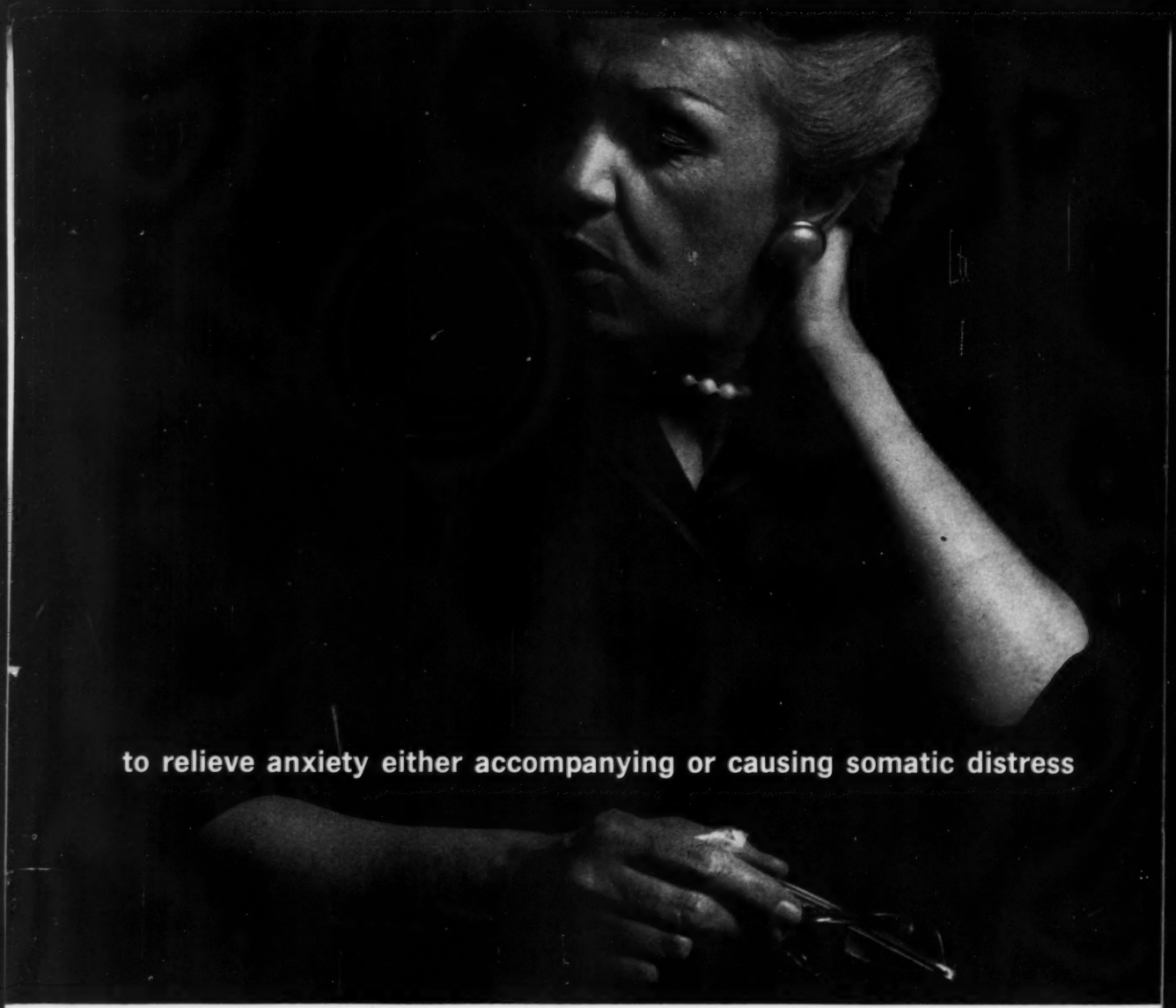
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

and . . . when your OB patient needs the best in prenatal vitamin-mineral supplementation . . .
OBRON®



advantages you can expect to see with Stelazine®

brand of trifluoperazine

- **Prompt control of the underlying anxiety.** Beneficial effects are often seen within 24-48 hours.
- **Amelioration of somatic symptoms.** Marx[1] reported from his study of 43 office patients that 'Stelazine' "appeared to be effective for patients whose anxiety was associated with organic—as well as functional disorders."
- **Freedom from lethargy and drowsiness.** Winkelman[2] observed that 'Stelazine' "produces a state approaching ataraxia without sedation which is unattainable with currently available neuroleptic agents; its freedom from lethargy and drowsiness makes ['Stelazine'] extremely well accepted by patients."

Optimal dosage: 2-4 mg. daily. Available as 1 mg. and 2 mg. tablets, in bottles of 50 and 500.

N.B.: For further information on dosage, side effects, cautions and contraindications, see available comprehensive literature, *Physicians' Desk Reference*, or your S.K.F. representative. Full information is also on file with your pharmacist.

1. Marx, F.J., in *Trifluoperazine: Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959, p. 89.
2. Winkelman, N.W., Jr.: *ibid.*, p. 78.

SMITH KLINE & FRENCH